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On The Cover: Winter has taken its toll in Van Saun Park, Paramus. The beauty of this 1982 bone-chilling scene is captured in the cover photograph by A. Olusegun Fayemi, M.D., a member of our Editorial Board. Dr. Fayemi is a pathologist, affiliated with Holy Name Hospital, Teaneck.

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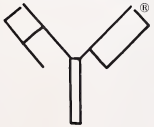
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Physician/Patient Relationships and Premium Discount Programs

Once a physician enters into a professional relationship with a patient, the relationship continues until it is terminated by the mutual consent of the parties or is revoked by dismissal of the physician or the patient. The relationship also may end as a matter of course when the services of the physician no longer are needed.

It is relatively simple for a patient to dismiss a physician. This can be done orally, in writing, or by seeking care elsewhere.

The termination of the physician/patient relationship by the physician requires more formality. Although a physician need not continue to treat any patient whom he does not desire to treat, he must follow certain procedures in order to avoid a possible charge of abandonment.

Once a physician has entered a physician/patient relationship, his duty to the patient can be breached not only by a negligent act, but by his unjustified or incorrect termination of the relationship. Abandonment can be classified into three categories: (1) refusal to treat a patient further or to treat the patient at an important or crucial time, whether or not another physician is available, (2) withdrawal of care without the consent or knowledge of the patient, or (3) premature dismissal of the patient when further care is needed.

When a patient is discharged, the following guidelines should be observed: The patient must be given notice, sufficient time to find another physician, opportunity to continue receiving care until another physician is engaged, and access to the file developed by the terminating physician. Often the physician may wish to give the new physician a written summary of his treatment rather than copies of the actual medical file. The amount of notice given will vary according to the patient's condition and the availability of other physicians in the terminating physician's specialty. It is suggested that this period be at least two weeks, but there are no hard and fast rules for this length of time. While the notice is in effect, the physician must remain available to treat the patient until the specified period has elapsed.

Although it is not required that a patient be discharged in writing, it always is advisable either to confirm a conversation or to discharge by mail. The letter should be sent to the patient's home, return receipt requested. A copy of the letter and the return receipt should be placed in the patient's chart.

A sample letter of withdrawal, taken from *Medicolegal Forms,* a publication of the American Medical Association, is shown in the example.

The private practice physician has the right to determine which patients he wishes to treat. Therefore, no specific reason for discharge need be given to the patient. However, when the reason relates to failure to follow advice or a similar situation, the physician may wish to indicate the reason in the discharge letter.

Whatever the physician's reasons for choosing to terminate the physician/patient relationship, it is essential that the termination be properly accomplished to avoid potential litigation. *Norcal Claims Rx,* Volume 3, No. 2, a publication of Norcal Mutual Insurance Company, September, 1982.

PRO-PHYSICIAN ATTITUDES ON PROFESSIONAL LIABILITY

The public has strong pro-physician attitudes on professional liability issues, according to a survey conducted by the AMA Group on Federation and Public Relations. Most people do not think that malpractice suits usually are justified, although 47 percent hold the opposite view.

A majority (61 percent) of the respondents in 1,504 telephone interviews favored limits on malpractice awards. Forty-seven percent of the public respondents think current malpractice awards are too high, while 7 percent think awards are not high enough.

Ninety-two percent of the 1,000 physician respondents in the AMA survey rated better physician-patient rapport as a very effective method for reducing professional liability risk. No other proposal for reducing risk—such as more peer review, continuing medical education, and risk management seminars—received more than a 38 percent approval rate.

On average, physicians in the survey estimated that 22 percent of malpractice claims are the result of actual negligence. Most physicians (62 percent) said hospital staffs should require evidence of professional liability insurance for staff privileges. *AMA Newsletter,* Volume 14, No. 35, November 1, 1982.

PREMIUM DISCOUNT PROGRAMS OFFERED BY PHYSICIAN INSURANCE COMPANIES

John Sargeant, C.A.E., Executive Director of Medical and Chirurgical Faculty of the state of Maryland, has collected the following data with regard to various premium reduction

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Director of Special Projects.

EXAMPLE

Sample Letter of Withdrawal

Dear _____:

I find it necessary to inform you that I am withdrawing from further professional attendance upon you for the reason that you have persisted in refusing to follow my medical advice and treatment. Since your condition requires medical attention, I suggest that you place yourself under the care of another physician without delay. If you so desire, I shall be available to attend you for a reasonable time after you have received this letter, but in no event for more than five days.

This should give you ample time to select a physician of your choice from the many competent practitioners in this city. With your approval, I will make available to this physician your case history and information regarding the diagnosis and treatment which you have received from me.

Very truly yours,

_____, M.D.

programs currently being considered or offered by physician-owned insurance companies.

Colorado: Considering a preferred provider rate that, after a year or two of coverage, would provide a percentage discount for those who have had no claims reported.

Florida: Considering a program to penalize (percentage not decided) those physicians who do not take the proposed risk management seminars.

Georgia: Offers a 10 percent, 8 percent, and 6 percent reduction in premium for attendance at 1½-day seminars sponsored by the Medical Association of Georgia; the charges for seminars are $150 for MAG members and $450 for nonmembers. Have increased membership in the association by this method by about 300. No real solid statistical information as to effectiveness of this program. Done because of competition with St. Paul. Qualifies for CME credit.

Maine: Considering a 10 percent a year premium reduction for attendance at risk management seminars.

Maryland: Considering some form of premium reduction for attendance at risk management seminars.

Minnesota: Physician-owned company offers no premium reduction, however, St. Paul does have a program similar to Georgia's discounts of 10 percent, 8 percent, 6 percent, decreasing each year for attendance at programs sponsored by St. Paul.

Mississippi: Discussing idea of premium reduction, but considered not appropriate. All new policyholders must complete a half-day program before expiration date of policy in order to renew. All moonlighting physicians must complete annually.

North Carolina: Offers 5 percent each year for three years, plus CME credit. Program runs three hours. Consists of film done by a leading plaintiff's attorney, plus defense counsel, and physician board member. Currently are tracking results in loss prevention and claims. Have had 2,500 policyholders' policies in North Carolina Mutual. Informal result to date would indicate that it has had a twofold effect: (1) physicians more willing to report cases and, therefore, they have seen an upswing in reporting with consequent change in reserving picture and (2) comments by some 83 percent of physicians that claims have been prevented by what they learned.

Ohio: State medical association has a group rate which is 20 percent under rate when purchased through membership in state medical society.

Oregon: Offers through its Aetna program, officially sponsored by Oregon Medical Association, a 7.5 percent discount each year for three years. Aetna underwrites costs of risk management programs that are arranged and presented through the Oregon Medical Association. The programs run about one-half day, start at 8:30 A.M., break for lunch, and end around 2:30 or 3:00 P.M.

Pennsylvania: No program, except automatically allows new physicians in practice a 50 percent premium reduction that will not be continued at 20 percent for second year unless they attend and complete a medicolegal course. Surcharge exists because of an individual's loss experience and this surcharge is reduced by 10 percent on completion of medicolegal course.

Oklahoma: For attendance at a one-day seminar presented by Oklahoma Medical Society, a premium reduction of 5 percent each year for three years is given.

New Mexico: Has program to allow 5 percent premium reduction each year, not cumulative, for four years in a row if policyholder attends the insurance carrier's own program.

Tennessee: Contract with Tennessee Medical Association to produce programs for which attendance at one would qualify for 10 percent premium reduction on renewal ($50 registration fee). (Attendance has been 450/550/750 at first three programs held.)

Texas: Considering a 6 percent premium reduction for attendance at risk management seminars.

No program of premium reductions for attendance at risk management seminars is currently being offered by: Alabama, Arizona, California (3 companies), District of Columbia, Illinois, Kentucky, Michigan, Missouri, New Jersey, New York, and Utah.

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5. Thou shalt maintain good patient relations by keeping an honest, concerned, and sympathetic attitude.
6. Thou shalt not communicate directly with the plaintiff or plaintiff's attorney.
7. Thou shalt not fancy thyself a trial lawyer.
8. Thou shalt not alter records in any way.
9. Thou shalt not promise good results.
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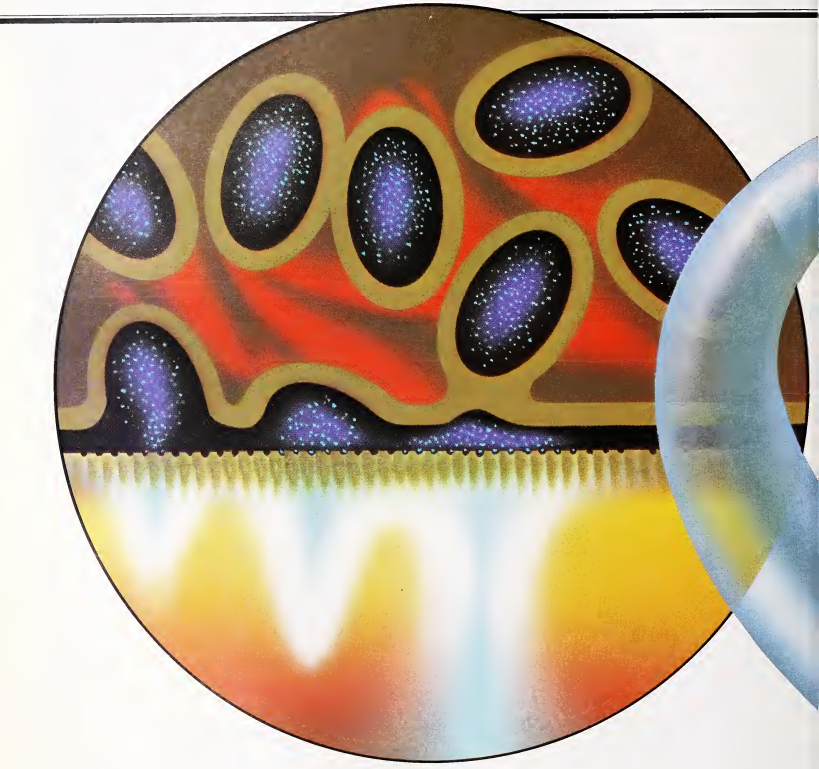
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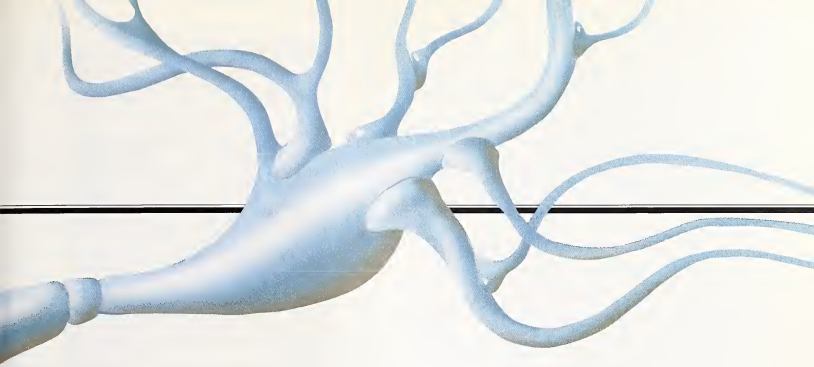
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New discoveries in receptor research have stimulated the search for endogenous brain substances that may be involved in the mediation of anxiety.[1-5] It has been further theorized that these substances may act as ligands that bind to the same or similar sites as do benzodiazepine molecules[5,6]—binding sites early identified with the use of ^{3}H-diazepam.[5,7] These binding sites are now postulated to be benzodiazepine receptors, since the ability of benzodiazepines to bind with the sites appears to correlate with their clinical effects.[2,4,7,8]

Present investigations into clinical relevance of binding sites. Laboratories at Roche have conducted research to identify and isolate substances that may prove to be endogenous ligands, but no definitive identification has yet been made. Researchers are also studying substances which do not bind, but rather interact with the benzodiazepine binding sites—most notably gamma-aminobutyric acid (GABA)—and are postulated to mediate certain pharmacologic and clinical benzodiazepine effects.[2-4,9,10]

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Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not as sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

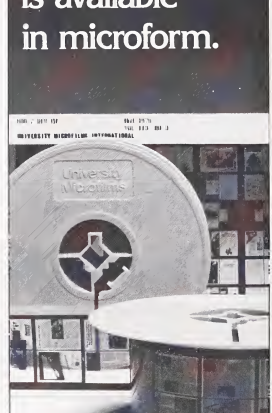
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References: 1. Tallman JF *et al: Science 207:*274-281, Jan 18, 1980. **2.** Bunney WE Jr: *Psychiatr Ann 11:*11-15, Jan 1981. **3.** Davis JM *et al: J Clin Psychiatry 42*(11) Sec 2:4-14, Nov 1981. **4.** Study RE, Barker JL: *JAMA 247:* 2147-2151, Apr 16, 1982. **5.** Braestrup C, Nielsen M, Olsen CE: *Proc Natl Acad Sci USA 77:*2288-2292, Apr 1980. **6.** Bosmann HB, Case KR, DiStefano P: *FEBS Lett 82:*368-372, Oct 1977. **7.** Braestrup C, Albrechtsen R, Squires RF: *Nature 269:*702-704, Oct 20, 1977. **8.** Snyder SH: *Psychosomatics 22:*986-989, Nov 1981. **9.** Rickels K: *J Clin Psychiatry 42*(11) Sec 2:40-44, Nov 1981. **10.** Haefely WE: *Br J Psychiatry 133:*231-238, Sep 1978.

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The FTC Issue

Recently, it seems more heat than light has centered in the Congress over the issue of what is the rightful role of the Federal Trade Commission (FTC) in regulating the professions. A spirited debate has crossed the country accusing the professions (read physicians) of wanting to escape regulation. Unfortunately, few even among the profession clearly see the implications of allowing a regulatory agency with subpoena power free rein to fish anywhere they want. Witness now the plight of the Maine State Medical Society which is under expensive investigation because they offered to assist the state of Maine in controlling Medicaid costs.

Organized medicine would leave statutory regulation of the profession to the states and to the Justice Department which now have that authority. Clearly, the FTC would like total authority. In the lame duck session of Congress, Representative James T. Broyhill introduced "compromise legislation" that would extend FTC regulation to those areas not covered by state regulation and to the business aspects of the professions.

There are several reasons why the Broyhill substitute is not a compromise:

1. The business and medical care aspects of a physician's practice cannot be separated. FTC activities already have damaged quality care by limiting physicians' and medical societies' ability to enforce professional standards, engage in peer review, and comment on poor performance records in the practice of medicine. FTC activities have caused medical societies to divert resources from establishment of standards, continuing education, and impaired physician programs to accommodate FTC inquiries. If the FTC is not limited in its jurisdiction, agency bureaucrats will have to make value judgments on the quality of care as it relates to marketplace elements.

2. It would allow the FTC to continue activities that already have proved harmful to the health care delivery system. For example, the FTC has stopped medical societies from initiating or participating in health care cost containment talks with state Medicaid programs because the FTC feels these talks are "collusive." The FTC prohibits medical societies from "interfering with the development or operation of any entity that offers physicians' services to the public," which would mean medical societies could no longer set standards of ethical practice—a service that protects patients.

3. If passed, the Broyhill amendment would grant the FTC the largest expansion of power since Magnuson-Moss in 1975. However, there have been no hearings on the Broyhill substitute. The Committee which reported out the FTC reauthorization bill did not have an opportunity to hear arguments on this measure. Congress needs to have an opportunity to hear all sides of the issue since the substitute actually grants the FTC authority over state-regulated professions that it has not previously been granted.

4. The Broyhill amendment would give the FTC power to preempt state laws. Under Broyhill, the FTC could invalidate statutes and regulations imposed by elected officials in the various states.

5. The substitute would not limit the actions of the FTC. In fact, the harmful activities of the FTC could not be stopped if the Broyhill substitute is passed. The measure does not address the concerns of the professionals with regard to the overzealous activities of the FTC.

The Luken-Lee amendment is a reasonable answer to the problem of the FTC intervention into the practice of state-regulated professions. It would place a moratorium on FTC activities, giving the Congress the time to thoroughly debate the issue and study the ramifications of the FTC jurisdiction over licensed professionals.

The entire historical self-regulatory function of our profession will be lost if the FTC has its way. We will survive, but our patients will have less and less protection. This concern must be communicated to the Congress so they can be aware of the true issues and can stop further unreasoning regulatory intrusion into the quality and quantity of health care.

James S. Todd, M.D.
Trustee, American Medical Association

Editor's note: On December 1, 1982, the House voted to exempt physicians and other state-licensed professionals from FTC consumer protection and other antitrust laws. This legislation prevents the FTC from investigating any individual or professional group that is regulated by state laws, agencies, or state-appointed boards. The AMA worked diligently to enhance passage of this exemption, which reflects deep dissatisfaction among congressional members over the enforcement policies of the FTC. It represents a significant benefit to organized medicine and individual physicans.

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Acute abdominal conditions: Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.
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Information for Patients: Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient taking this drug should be cautioned accordingly.
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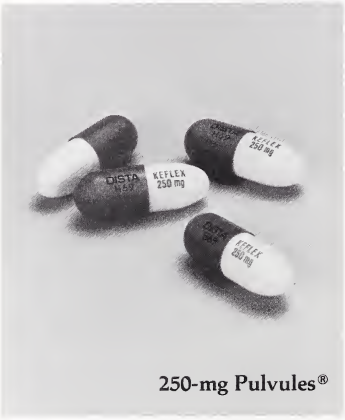
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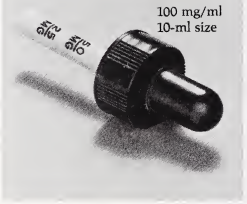


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The Hospital Leadership

A troika is a Russian carriage or wagon drawn by a team of three horses abreast or, in a political sense, a group of three persons or nations acting equally in unison to exert influence, control, or leadership. A triumvirate is a government of three officers or a coalition of three rulers for joint administration, i.e. any group or set of three. Lest there be any confusion, it must be made clear that hospital leadership is not a troika, but a kind of triumvirate whose hierarchy is led by the hospital governing board, the chief executive officer, and the hospital medical staff.

The hospital governing board (HGB) "has the ultimate authority and responsibility for patient care and for the overall quality of service in the hospital"[1] and "has the obligation to demonstrate leadership in determining the institutional mission and in establishing a strategic plan that is consistent with that mission and with the resources available in the community."[1]

In the final analysis, the HGB owns the hospital and despite the fact that the governance and management of the institution must be shared functions of the three groups, the governing board retains the "ultimate authority and responsibility"[1] to itself.

THE RELATIONSHIP OF THE HOSPITAL GOVERNING BOARD AND THE HOSPITAL MEDICAL STAFF

In the bad old days, the relationship between the HGB and the staff was aloof at best and confrontational at worst. Although the trustees knew that they were responsible to the community, to the government, to the courts, and to themselves for the conduct of their institution, doctors, individually and collectively, deluded themselves into thinking that the hospital was their turf and that they had some kind of intrinsic right of eminent domain. With the passage of time, HGBs were encouraged by national organizations to extend full voting membership on the board to one or more selected physicians who may or may not be on the medical staff. Physicians were encouraged to attend all board meetings, to speak on all issues, and to clarify medical concepts and questions to lay members of the board. The HGB maintained the authority and responsibility for ensuring proper organization of the institution's medical staff and for monitoring the quality of care provided under the auspices of that institution."[1] This includes a need to ensure that the physician's continuing medical education programs "meet the needs of the institution's patient population."[1]

Other functions include:

- The monitoring and reviewing of the quality of medical care in the institution through quality assurance programs.
- Approving or disapproving all medical staff appointments.
- Delineation of clinical privileges.
- Approval of the medical staff's organization and bylaws.

Since board members vary from bankers to school principals to college presidents and large business representatives, they have a huge disadvantage when it comes to technological needs, physician qualifications, evaluation of the quality of professional health services, and the like. They may be torn between rubber stamping and nit picking, neither of which may be the best course. In the final analysis, the board should ask itself, "What is best for the patient and for the community?" This proves to be the bottom line in decision making.

THE MEDICAL STAFF

Physicians primarily are accountable to the board for the quality of medical care provided in their hospital, but their total responsibilities go far beyond that. They must be cognizant of, conversant with, and informed about public policy issues that may influence the delivery of health services in their institution. They must play an active role in representing their hospital in external matters, in strategic

*The material for this column is coedited by Arthur Krosnick, M.D., Editor of *The Journal*, MSNJ; Vincent A. Maressa, Executive Director, MSNJ; and James E. George, M.D., J.D., Director of the Department of Professional Liability, MSNJ.

inhospital planning, and in cost-effective management of resources. Physicians must "help create a favorable environment for recruitment, development, and retention of nurses and allied health professionals, as well as a climate in which they can function effectively."[1]

In the interest of quality care, physicians are obliged to evaluate the composition of their medical staff and must develop criteria for membership recruiting, selection, and retention. Educational activities in the hospital must meet established standards of high quality. A system of self-evaluation and discipline is crucial for the hospital staff.

If the hospital takes part in research the triumvirate shares the responsibility to ensure the patients and the community that proper standards and procedures are established and followed, under the scrutiny of the Institution Review Committee, in order to protect the researchers, the hospital, and participating patients.

SUMMARY

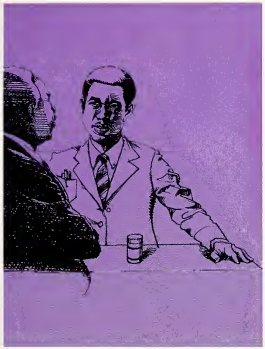
The shared responsibility of the hospital governing board and the medical staff and their separate but heavy duties to the patient population and the community are rapidly growing more awesome. The complexities of health economics, scientific and technological advances, governmental regulations, and the litigious nature of the consumers of health care services tend to rock board and staff members back on their heels.

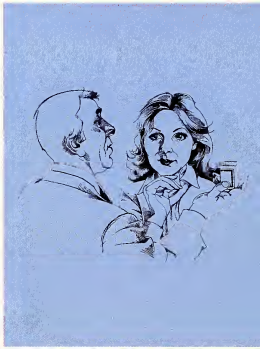
Instincts may stimulate involved individuals to run for cover screaming, "Why me? Why not you?" Physicians and board members alike must don the mantle of accountability, expunge the concept of confrontation, and seek to lead their hospital into an atmosphere of trust, cooperation, and mutual respect for the benefit of the institution, its patients, and its community.

REFERENCES

1. The American Hospital Association: *Guidelines. Role and Functions of the Hospital Governing Board.* Chicago, IL, 1982, pp. 1-4.





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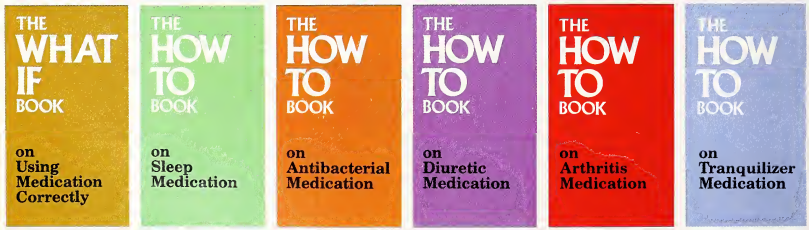
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Discharge Date Setting: The Physician's Responsibility

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Deciding early in the patient's stay on the discharge date and the physician's confirmation of it with the patient sets a goal, tempers anxiety, and aids in rehabilitation effort.

The purpose of this article is to review and tighten the relationship between the physician's use of the discharge date and the patient's motivation to recover.

Organizational theorists Eugene Webb and Karl Weick wrote a zesty definition of the phenomenon we call deadline:

> The history of the word deadline shows it to be grounded in an engagingly attractive organization control mechanism. Its nineteenth century beginning was as a line drawn in the dirt around a group of prisoners. Anyone stepping outside the line significantly shortened his life span. Currently, deadlines are less noxious. They serve as general control devices for both individuals and organizations, signaling the seasons for some organizations and setting a rhythm for the activities of the organization's members.[1]

In a study of the discharge planning system in a rehabilitation institute, unexpected data about deadline setting behavior of physicians emerged. Since the physician is expected to set the discharge date, a consideration of these findings by physicians and other health care personnel may contribute to greater precision in discharge planning and may diminish some of the stress involved. Since many patients in acute care hospitals become chronic care patients, these findings may be useful in those settings as well.

The physician always will carry the ultimate responsibility to set the discharge date. The important word is ultimate because, in contemporary health practice, many others are encouraged to contribute to the decision-making process. Research has shown, however, that professional coworkers do not always perceive the physician as supportive of discharge planning even though the physician's role is recognized as central to the process. In a study of 14 Chicago area hospitals, members of the discharge planning team including directors of nursing and utilization review, social workers, and home care coordinators described the physician as the least supportive member of the discharge planning team and at the same time playing a pivotal role in authorizing and endorsing posthospital care.[2]

THE PATIENT'S DEADLINE

In rehabilitative care, "the" date for leaving is dramatically important for most patients and they will go to great lengths to find out when it is. This intense quest contains a paradox: even when a patient and perhaps the family has been involved in planning for discharge all along, the patient still looks to the doctor for that explicit go ahead.

According to Roth's analysis of patient "timetables," physicians attempt to avoid any commitment on the length

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of time of a particular treatment or stage of treatment, although this uncertainty in prognosis causes stress for patients and staff alike.[3] The patients generally are aware that the members of the team will be discussing their progress with the doctor and often seek to find out such information from hospital staff. These gleanings usually are reported back to the physician for confirmation. The staff may use the convenient, accurate phrase, "It's up to the doctor," and the physician may say "I want to discuss it with the team," but eventually the doctor is expected by the patient to set a date.

RELEVANT LITERATURE

Research on the history and use of deadlines appears in two kinds of literature, the first having to do with well people in organizations and the workplace including the sports arena, and the second in the psychological literature focusing on crisis intervention theory. Arvedson has done the most work on deadlines in organizations.[4] According to Arvedson, deadlines have an energizing effect and particularly so when people are led to believe that they have a long versus a short deadline.

The psychological literature includes studies of those who, suffering trauma from sudden and unexpected situational crises or displacements, were found to be helped by crisis intervention techniques—one of which is the use of deadline setting as a therapeutic tool.

Erich Lindemann is regarded as the father of crisis intervention theory. From his work on the crisis of bereavement experienced by the survivors of the Coconut Grove fire in 1943, Lindemann developed the process now referred to as "grief work."

"In rehabilitative care, the date for leaving is important for most patients and they will go to great lengths to find out when it is."

Gerald Caplan, Howard Parad, and Lydia Rapoport at Harvard University refined the theory and developed crisis intervention techniques with populations-at-special-risk. According to Rapoport, a crisis situation creates a problem that can be perceived as a threat, a loss, or a challenge. Three interrelated factors usually produce a state of crisis: a hazardous event, a threat to life goals, and an inability to respond with adequate coping mechanisms.[5]

For most patients in a rehabilitation setting all three factors usually are present since a major physical illness is a life crisis. In addition to the grief over the loss of physical health, there are disruptions in family life, job performance, and income production and a severe lowering of the feeling of self-worth.

Schontz identifies five stages commonly experienced by individuals in crisis: shock, realization, defensive retreat, acknowledgement, and adaptation. The individual usually completes the stages of crisis in five to eight weeks.[6]

Many crisis reactions, according to Smith, involve a significant loss. He recommends a treatment plan based on three generic tasks:

1. The patient needs to recognize the loss and express feelings about the loss.

2. The patient needs to explore with a member of the treatment team how the loss can be compensated.

3. The patient needs to implement some activity that will compensate for the loss.[7]

Applying crisis intervention techniques requires learning from the patient (or the family if the patient is not able to speak) what major hazardous event has occurred in the recent past, when it was, and where the patient is along the crisis continuum. The actual event may not have been the illness that required hospitalization, but some other crisis such as job loss or death of a spouse. Once having established what the hazardous event was and how it happened, a simple estimate can be made of how much time is available within a five to eight week period. Even if the time has elapsed, the establishing of the hazardous event and tracing it to the present will give a good sense of the patient's coping abilities.

The number of studies and articles on some aspect of discharge planning has increased significantly since the mid-1970s. As one example of heightened attention, in 1980, the American Hospital Association, through its Society of Hospital Social Work Directors, began publishing a discharge planning quarterly with an intent to address discharge planning in an interdisciplinary format.[8] The first volume includes the presentation and evaluation of discharge planning models in use around the country.

Other literature published on discharge planning includes studies of unique professional perspectives,[9] followup studies,[10] and services for the care of patients after discharge.[11,12] Nearly all the literature acknowledges the key role of the physician, but to my knowledge, there have not been any studies reported in the literature about the physician's approach to setting a date for the patient's discharge. While at first glance this focus appears narrow, it is a manageable way to look at a many-faceted patient-care issue. "The" date is only the tip of an iceberg covering other complex questions about insurance coverage, bed occupancy, staff-patient ratios, and legal and ethical issues. Health care professionals, nonetheless, still place a very high premium on predicting and evaluating how a given action impacts on the patient; therefore, it is useful to learn as much as possible about how physicians deal with a deadline which signals a change in life circumstances for the patient and all that is implied by a termination of inpatient service and a return to the community.

RESEARCH DESIGN

Organizational inquiry involves three steps—design, data collection, and analysis. The research design used in this study was exploratory-descriptive. It was exploratory in the sense that it attempted to conceptualize the interrelationships among aspects of the discharge planning process. In its application, exploratory-descriptive research in addition to contributing to knowledge is designed to be of practical value to practitioners, planners, and administrators.

The study was carried out by the author between November, 1981, and March, 1982, at the Robert Wood Johnson Jr. Rehabilitation Institute, Edison.

For the purpose of this study, discharge planning is defined as a coordination of services that facilitates the continuity of health care that takes into consideration unique needs of each patient. These needs encompass medical, rehabilitation, nursing, therapeutic, psychosocial, familial, and financial aspects as well as the prior lifestyles of the patient. In this regard, it is an interdisciplinary collaborative effort including participation to the fullest extent possible of the patients and their family or significant others and the treatment team.

The institute's policy requires continuing assessment of the discharge plan of all patients throughout their stay which takes into account changing conditions, awareness and ability of the patients and/or families to cooperate with the plan, and the availability of community resources.

Data collection methods included systematic observation, interviews with key staff, and review of available data such as policy and procedure manuals. The four physicians, direct service personnel, and supervisory personnel were interviewed. The 32 observations about the physicians' deadline setting behavior were made during the study period as they occurred in the weekly regular discharge planning conference.

The objectives for the study were: to describe selected operational aspects of the discharge planning system; to identify factors that impede the system from achieving its goals; and to suggest guidelines for discharge planning.

FINDINGS

Before considering the specifics of setting deadlines, it is useful to describe the context, the system within which the decision is made.

Inpatients are cared for in modules of approximately 12 patients each. Ordinarily, patients remain in the module to which they are assigned at admission. A physician is the team leader for each module. In the module system, there are key points along the continuum of care when the module physician and the team will deal with the patient's posthospital plan. These key points are: initial workup, ongoing clinical contact, team rounds, discharge planning conference, and followup appointments. They are a mix of one-on-one assessment and team assessment.

One of the criteria for admission is the prospect of a feasible posthospital plan for return to the family and/or community. Nonetheless, knowledge of the life-changing effects of most major disabilities on patients and families requires that planning for postdischarge continues while the patient is in care and often even after a return to the community. The first key point of exchange is the "initial workup" which presents an opportunity for a thorough review of past developments and future prospects. Also, it is an opportunity for the initiation of a relationship between the physician and the patient that can carry the patient through the weeks and months ahead. Ongoing clinical contact is the second opportunity available to the physician and the patient.

In this rehabilitation setting much of patient care is team care. By means of team rounds and the discharge planning conference, the staff has the opportunity to provide collegial assessment of all patients at regularly scheduled intervals. Both team rounds and discharge planning conferences are chaired by the module physician.

Team rounds are held weekly from 12:30 to 1:30 P.M. in the patient day room in one of the units. Team rounds include all members working directly with the patient. In addition to the physician, who presides at the head of the table, the occupational therapist, physical therapist, nursing staff, social worker, recreational therapist, and dietary staff contribute to patient assessments. Every patient is reviewed every other week. The physician reports any outstanding observations from clinical contact and, if necessary, reviews highlights from the patient's history. It is customary that a current appraisal of family and community resources and the patient's views of these factors be made available by a social worker for discussion in team rounds. A rough approximation of the length of stay for a patient then is developed by the module team. It is rare that a specific date for discharge is set at team rounds.

The discharge planning conference is held every Thursday from 10 to 11 A.M. in a room near the outpatient department. The primary purpose of the conference is to set or reconfirm a date for discharge and clear this date in relation to the schedule of admission and discharge for the entire rehabilitation division. Patients are reviewed every other week; as they get closer to discharge they may be reviewed every week.

"I did not expect to find that each physician followed a different method of date setting and at the same time consulting the team members about each patient."

This conference is chaired by the same physician who chairs module team rounds. The members of this conference are the supervisory staff who may have firsthand information about the patient. The physician sits at the head of the table with a list of patients and checks briefly on patients who have a date set, noting any new developments. If nothing is noted to the contrary, the date is reconfirmed. The rest of the patients are discussed briefly, one by one, and each of the therapy supervisors comments on readiness based on reports prepared by the direct service personnel. Once a tentative date is chosen, a reconciling process goes on with the list of patients already scheduled. The purpose of this process is to assure that not too many patients will be coming in or leaving on the same day.

I expected to find an orderly, comprehensive system for the evaluation and discharge of patients and that the physician was engaged in the process and was central to it.

I did not expect to find that each physician followed a different method of date setting and at the same time consulting the team about each patient.

The four methods used were: setting the discharge date early in treatment; setting the discharge date two to three weeks before discharge; doing a week-by-week evaluation and then setting the discharge date at the minimum two-week limit prior to discharge; or routinely setting the discharge date at the minimum of two weeks prior to discharge. There was no standard procedure for informing the patient either about outcome of the particular discharge planning conference or the confirmation of a discharge date.

The physicians' reasons given to support delay in setting a date for discharge were varied. If patients know about their discharge date too early they will devise some way to stonewall their departure, thereby becoming management problems. Another reason was the hope that there will be some last-minute improvement through extra effort with the patient and/or family and community, warding off the prospect of nursing home placement or return to a poor home care situation where the hard-won rehabilitation gains would be lost.

According to the physicians, their philosophy of rehabilitation included the premise that physician and patient are bound together for the long journey and any particular discharge date was only one in a series of dates. And finally, since most patients have suffered considerable bodily and emotional damage, real certainty about a discharge date is

less important than easing day-to-day discomforts. To counter these stated reasons for delay in naming a discharge date, there were data to show that, in fact, patient outcomes were different. The largest percentage, 86 percent, of patients do go home with, in the judgment of the staff, a good chance of being able to manage. A much smaller group, 8 percent, will go back to the community to what I call a "jerry-built" support system consisting of neighbors, visiting nurses, or family members who are themselves in poor health or marginal circumstances. An even smaller number, 6 percent, of patients will go directly to a nursing home, most likely after a long waiting period. Less than 3 percent of the patients make any concerted effort to dig in and conjure up reasons not to leave.

CRISIS INTERVENTION THEORY

Not to use crisis intervention theory in work with rehabilitation patients is to ignore 40 years of research and practice. In examining the factors that constitute a crisis, namely a hazardous event, a threat to life goals, and an inability to respond with adequate coping mechanisms, it is clear that patients in the rehabilitation setting are in crisis even though it may not be visible outwardly. The same may be said to be true of family members.

One of the essential findings of crisis theory is that 5 to 8 weeks are needed to resolve a crisis. During this time most patients with the help of the physician and other team members can prepare to deal with the current crisis and for whatever comes next—a return home, a nursing home, or a new round of disability. Assigning a discharge date as early as possible encourages conscious, maximum use of the time of inpatient stay and fosters the use of the discharge date as an aid to treatment.

Crisis intervention theory suggests that individuals complete the stages of crisis in 5 to 8 weeks. The average length of stay in the rehabilitation institute strikingly is similar, 38 to 56 days. When the physician and other team members assign a discharge date between 10 to 14 days after admission, maximum use can be made of the time. If it has to be changed, so be it, because for most patients there do not appear to be persuasive reasons to delay. The date must be communicated by the physician.

The recommendation that the physician take responsibility for communicating the discharge date in no way diminishes the necessary involvement of the patient, the family, and the other team members in establishing the date. Rather, the recommendation recognizes the strength and importance of the relationship with the physician as the person who can focus and motivate the patient in the recovery period.

DEADLINES

Studies of the workplace and the sports arena suggest a deadline is energizing. In other words, a deadline well used can be a lifeline! Physicians deal with deadlines all the time. Discharge deadlines external to the patient are built into cost-benefit mechanisms such as insurance and the Diagnostic Related Groups (DRGs). Physicians also use internal deadlines inherent in the course of an illness cycle to plan stages in a patient's recovery. Commonly used reasons for delay in deadline setting include individual rates of recovery and medical and/or emotional complications. Additional reasons for concern on the part of physicians and other personnel about the return of the patient to the community amply have been documented in the literature; namely, the inadequate support services, the limited range of services, and the failure to coordinate such services.

What appears to have received less attention is the frustration and discouragement of the physician and other treatment team members when trying to help patients who, while fewer in absolute numbers, severely are limited by health, age, income, and housing combined with a vacuum in community supports. Another source of frustration is the institution's need to economize, maintain 100 percent occupancy of beds, and comply with constraints of insurance coverage—all of which may interfere with preferred planning procedures. These frustrations, however, must not so influence the discharge planning system that patients are deprived of information, a deadline to work toward, and an opportunity to master a transition in life even when the options seem meager.

The study reported in this article points toward recommendations that are in accordance with crisis theory which provides the framework for minimum intervention designed to have the maximum effect of tempering anxiety, lessening the likelihood of psychological disorganization, and facilitating the rehabilitative effort.[13]

SUMMARY

Patients in a rehabilitation institute move in and out of crisis during their stay. Setting a discharge date often is delayed because of individual rates of recovery and inadequate resources in the community. Deciding early in the patient's stay on a discharge date, even if it must be changed, and confirming it with the patient is more in accord with crisis intervention theory and the use of deadlines as energizing and therapeutic.

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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Initial Management of Eye Trauma

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The prognosis for vision from a ruptured globe has improved over the past five years as a result of new medical technology. A technique for evaluating the severity of an eye injury by a nonophthalmologist, how to transport the patient, and when to refer an eye injury to an ophthalmologist is described.

The ability of the ophthalmologist to salvage traumatized eyes has improved greatly. With the evolution of tissue extractors, operating microscopes, and ocular ultrasonic equipment, only the most severe ocular injuries are irreparable.

Bell reported that there were over 280,000 eye injuries in the United States in 1978.[1] The National Eye Institute estimates that over 2 million eye injuries occur each year. Maltzman, Pruzon, and Mund reviewed all admissions to the Newark Eye and Ear Infirmary and found that 7.5 percent were for eye trauma.[2] In 1978, 12 percent of all eye injuries reported were related to sports.[1]

According to Lim and Cinotti, during a 22-year period, the major cause for enucleation at the Newark Eye and Ear Infirmary was eye trauma.[3] In 1976, Cinotti and Maltzman declared that 70 percent of eyes were lost when vitreous humor was involved.[4]

In recent years, authors have reported a much more favorable prognosis for seriously traumatized eyes since 1975.[5] This is a direct result of microsurgical techniques and new instruments that permit eye surgeons to take a more aggressive approach to eye trauma.

The purpose of this paper is to discuss the management of an eye injury from the time it is seen by the private practitioner or the emergency room physician in order to ensure that the best modalities are used to preserve vision.

EVALUATING THE INJURY

The first physician to see the patient usually is not an ophthalmologist, but he should be capable of insuring that the patient gets the best care. After a thorough history, look for any other injuries. Does the patient need emergency care? Are there any associated medical problems or allergies?

Take a specific eye injury history as to the time and date of the accident and how and where it occurred. If a foreign body is suspected—was it glass, wood, or metal? If caused by blunt trauma, what was the object—a fist or a soccer ball? Was it due to a firecracker blast? If it was a chemical burn, was it acid or alkaline?

PHYSICAL EXAMINATION OF THE EYE

In evaluating the condition of an injured eye, do not fail to measure the vision in each eye. If the vision is good, or equal to the other eye (with glasses, if worn), then it is probable that the injury is not severe. If the vision is reduced and there is no history of poor vision prior to the trauma, the physician must be doubly careful to find the cause for the decreased vision. If a Snellen chart or near-vision card is not available, use a calendar, book, or newspaper. Recording the visual

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acuity also can be of great help if medical-legal problems arise.

Painful or swollen lids may prevent the patient from opening the eye. A drop of anesthetic from a new bottle may be used to relieve pain. Before opening the lids, inspect them. Are there any lacerations, abrasions, or ecchymotic areas? If the eyes have to be held open, do not use excessive force or press on the eyeball. Use a flashlight to inspect the cornea, conjunctiva, sclera, iris, and pupil. Note any abnormalities. For abrasions or breaks in the epithelium of the cornea, a drop of fluorescein will outline the area involved. Always attempt to visualize the fundus for gross evaluation of the clarity of the media and integrity of the posterior segment of the eyeball.

"If the vision is good or equal to the other eye and the anterior segment appears normal, the injury usually is not serious."

If the vision is good or equal to the other eye and the anterior segment appears normal, the injury usually is not serious. However, intraocular foreign bodies have been known initially to give the appearance of a "quiet" eye and later to affect vision.

IMMEDIATE TREATMENT

Chemical burns require copious irrigation even if done soon after the injury. This should be done even before determining the vision. An acid burn causes immediate damage, but its effect is diminished by tears. An alkali burn is slow because the chemical penetrates the eye tissues and destroys them from within, even after irrigation.

Blunt trauma can cause damage to many eye tissues, but often will show only minimal or subtle signs. A short list might include rupture of the globe, blowout fracture of the orbit, hyphema, contusion or rupture of the iris with mydriasis, iritis, dislocated lens, cataract, glaucoma, choroidal, and retinal tears and retinal detachment. Treatment of these conditions should be left to the ophthalmologist.

Early diagnosis and proper management of a lacerated globe is critical. Survival of the eye depends on controlling infection, maintaining the intraocular pressure, and restoring its anatomical integrity. Tetanus prophylaxis should be administered and the ophthalmologist should be called immediately.

A "red" eye is a problem in differential diagnosis whether trauma is suspected or not. Surface foreign bodies, subconjunctival hemorrhage, conjunctivitis (bacterial, viral, allergic, or chemical), iritis or uveitis, and acute glaucoma are some of the possibilities.

Blowout fractures often are preceded by a history of blunt trauma to the face. The eyelids often are ecchymotic and edematous. If the infraorbital rim has been crushed, the patient complains of numbness of the ipsilateral cheek area and gums. Try to determine if diplopia is present. Diplopia usually results from an injured muscle which is edematous and functioning poorly. Usually, it is not a muscle trapped in the fracture; therefore, surgical intervention is not indicated for diplopia alone.

If a patient has been hit in the face, develops a "black" eye, and notes eyelid swelling after blowing his nose, a fracture of the ethmoid sinus can be diagnosed. The edematous lids are puffy, but crepitation can be palpated in the upper lid. Treatment of this fracture with antibiotics and antihistamine medications is indicated.

In acute glaucoma, the eye often is red and painful and the pupil is dilated and fixed. Nausea and vomiting can become more prominent than the eye symptoms. A Schiotz tonometer should be used to measure the ocular pressure.

Keep in mind that the injury probably is not serious when the vision is good or equal to the other eye and the anterior segment is intact. Treatment of the obvious problems should be given. Small lacerations of the lid that do not extend through the lid margin may be sutured. Foreign bodies may be removed with irrigation or with a 25-gauge needle.

Infectious conjunctivitis generally causes the lids to stick together on waking. An anophthalmic sulfa drop may be prescribed. Allergic conjunctivitis causes itching, for which a nonsteroid eye drop such as Vasocon-A®, Albalon-A®, or Naphcon-A® may be ordered. Subconjunctival hemorrhages require no treatment. If iritis or acute glaucoma is suspected, definitive treatment will be needed.

Be on guard for a somnolent child following any kind of eye injury. If a child is very sleepy, slow to respond, or hard to arouse, a lacerated eye is very common.

TESTING AND TRANSPORTATION

After the initial examination, x-rays of the chest, abdomen, or skull may be indicated. If skull films are indicated, request a Water's view which is helpful in ruling out a blowout fracture of the orbit. If an intraocular foreign body is suspected, inform the radiologist to take the proper films. Ultrasonography of the eye often is diagnostic.

If the injury is severe, patch the eye and put a shield over the patch. Do not use a pressure patch as it may extrude the contents of the eye through a laceration. If a shield is not available, make one with a piece of cardboard and cover it with sterile gauze.

If the injury is not severe but the patient is unreliable and a followup visit with an ophthalmologist is desirable, patch the eye anyway. This will impress the patient that the injury is severe enough to warrant making a followup visit.

If there is any question as to the severity of the injury, call an ophthalmologist. He will examine the patient and evaluate any studies that have been ordered. He will try to determine the extent of the injury. A retinal evaluation is done. If the fundus cannot be visualized, the ophthalmologist may perform an ultrasound examination. If equipment is not available and the fundus still evades visualization, the patient should be transported to a center where ultrasound can be performed.

DISPOSITION

Since conditions such as glaucoma, iritis, or retinal detachment frequently follow even minimal eye trauma, it would be prudent to have the patient seen by an ophthalmologist within 48 hours. In addition, the Ocular Trauma Hot Line can be used. The hotline functions in a fashion similar to a poison control center, i.e. advice can be obtained immediately by telephone. If necessary, the patient can be transferred to the New Jersey Ocular Trauma Service which is based at the Eye Institute of New Jersey.* There are eye physicians with training in eye trauma on call 24 hours a day.

*15 South 9th Street, Newark NJ 07107.

THE LACERATED GLOBE

Early diagnosis and proper management are critical. Survival of a lacerated globe depends on controlling infection, maintaining intraocular pressure, and restoring the anatomy of the eye. Coleman pointed out that early vitrectomy, based on ultrasonography, often is indicated to restore anatomical integrity and to try to prevent the formation of massive preretinal fibrosis which may cause scarring of the visual axis, traction retinal detachments, or hypotony (very low pressure).[6] There now is universal agreement that a vitrectomy should be performed within 14 days after the injury if these conditions exist. The key to saving such a severely traumatized eye, in which the retina cannot be visualized, is ultrasonography.

The initial repair and stabilization of a lacerated globe can be done in most New Jersey hospitals where eye surgery is performed, even without the aids of vitrectors and ultrasound. Although a complete restoration of the anterior segment may not be possible because one would not know the position of the retina or the extent of the injury, the closing of the eye prevents the extrusion of the intraocular contents and lessens the danger of infection. The patient then could be transferred for a more definitive procedure. Continued microsurgical technique is required. Only nonabsorbable sutures are used; for the cornea use fine 9-0 to 10-0 sutures; for sclera, heavier 7-0 to 8-0 sutures are needed. If the need for anterior or posterior segment reconstruction has been confirmed and is feasible, the equipment and personnel are available, and the surgeon is confident in the diagnostic and surgical skills of his team, definitive repair can be attempted at the initial surgery.

"Survival of a lacerated globe depends on controlling infection, maintaining intraocular pressure, and restoring the anatomy of the eye."

If not, the eye should be reevaluated in 48 to 72 hours in anticipation of restorative surgery; that is the time to consider an even more comprehensive evaluation possibly using the slit lamp microscope, indirect ophthalmoscope, ultrasonography, electroretinal studies, and consultation with another ophthalmologist. Usually, within a 14-day period after the initial injury, the decision as to the need for secondary intervention will be made, be it anterior segment reconstruction, vitrectomy, or retinal detachment repair.

SUMMARY

Most eye injuries are seen initially by nonophthalmologists. This article puts forth a simple way to perform the initial evaluation of an injured eye without specialty training. Advanced techniques on how to salvage severely injured eyes are reviewed.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington; M.D.; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Use of a Pulmonary Function Laboratory in Central New Jersey

PHILIP L. SCHIFFMAN, M.D., MARTIN F. MAZAR, M.D.,
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Review of the results of pulmonary function testing in 300 consecutive patients revealed a surprisingly high percentage of abnormal results. This suggests that the clinical sensitivity for performing such tests is too low.

Much concern recently has been voiced over the rapid escalation of the cost of health care, with special attention paid to that fraction devoted to technology.[1-4] Relman points out that 30 percent of the $110 billion increase in health care costs between 1969 and 1978 may be attributed to the increased use of technology.[1] Fineberg and Hiatt cite similar percentages (25 to 50 percent) for the technical component of the rise in hospital costs since the 1950s.[2] Evaluation of cost effectiveness and, where necessary, restriction of the implementation or use of expensive new technology has been suggested.[2,3] Rationing the less expensive but more profuse "little-ticket" items (small tests and procedures often considered routine) also has been advocated to solve this problem.

Evaluation of some commonly used tests, such as the chest x-ray and the partial thromboplastin time, has shown in some instances low yields of abnormal results prompting reevaluation of the indications for the use of those tests.[5-7] The following study sought to evaluate the utilization of a pulmonary function laboratory.

METHODS

Pulmonary function records of 300 consecutive patients referred to the Pulmonary Function Laboratory at Middlesex General Hospital (exclusive of patients referred solely for arterial blood gas studies) were reviewed and the following data were collected: age, sex, smoking history, inpatient or outpatient, diagnosis, chief complaint and reason for referral, and attending physician (all routinely are recorded). Referring physicians were categorized as medical or surgical practitioners. Pediatricians, internists (and subspecialists), general practitioners, and family practitioners were classed as medical. Additional note was taken of those internists who practice a pulmonary medicine subspeciality. Surgeons (including subspecialists) and gynecologists were classified as surgical practitioners. Additional note was taken as to whether patients specifically were referred for preoperative testing or for disability evaluation (i.e. for compensation from the Department of Labor, Social Security, the state, or insurance company).

Tests varied between patients. Some underwent simple spirometry; others underwent spirometry and some or all of the following: lung volumes by helium mix, postbronchodilator spirometry, single breath carbon monoxide diffusing capacity, maximum inspiratory and expiratory flow volume loops, and static lung compliance. For this study, patients are called normal if all the studies they had done were normal. They are called abnormal if any of the studies

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TABLE 1
Patients (n=300)

Subgroups	Number
Male/Female	199/101
Smokers/Nonsmokers	204/96
Adult/Pediatric*	289/11
Inpatients/Outpatients	80/220
Medical**/Surgical	280/20
Medical***/Pulmonary	200/80
Preoperative evaluation	18
Disability evaluation	61

*under 18 years
**includes pulmonary subspecialist
***excludes pulmonary subspecialist

TABLE 2
Abnormal Studies

Category	Percent Abnormal
All patients	90.0
Inpatients/Outpatients	96.3/87.7*
Medical/Surgical	89.6/95.0
Medical/Pulmonary	92.5/82.5**
Disability evaluation	98.4
Preoperative evaluation	94.4
Preoperative-outpatient	90.9
Preoperative-inpatient	100.0

*Significant difference p<.03
**Significant difference p<.02

TABLE 3
Normal Studies

Diagnosis or Indication	Number
Sarcoidosis	4*
Compensation evaluation	1
Asthma	9**
Pulmonary embolism	1
Chronic cough	3
Pectus excavatum	1
Dyspnea	9****
Preoperative evaluation	1
Radiation fibrosis	1***

*All biopsy proven; two previously had abnormal PFTs.
**Two had previously abnormal PFTs; one had hypoxemia by arterial blood gases, one on bronchodilators at time of study.
***Previously restricted—only study on this visit was static compliance.
****One complained of cough and dyspnea; one patient had three studies.

were abnormal. Patients who had studies performed on more than one occasion had each occasion interpreted separately, whether the same or different tests were performed. The equipment used to perform these tests meets or exceeds the specifications recommended by the American Thoracic Society[8] and the American College of Chest Physicians.[9]

Criteria used for classifying a test as abnormal are as follows: lung volumes—less than 80 percent of predicted values of Goldman and Becklake;[10] FEV_1—less than 80 percent of the predicted values of Cotes et al.;[11] flow rates—less than 1.64 standard deviation below the mean predicted values (outside 95 percent confidence limits as only low flow rates are considered abnormal) of Kory et al.;[12] FEV_1/VC—less than 75 percent; static lung compliance—less than or greater than two standard deviations from the mean of the predicted values (outside 95 percent confidence limits as both an overly stiff and overly elastic lung are considered abnormal) of Turner et al.;[13] and diffusing capacity—less than 75 percent of the predicted values of Ayers et al.[14]

Statistical significance was evaluated comparing proportions abnormal between groups using two-tailed Z tests.[15]

RESULTS

Patients are characterized in Table 1. Approximately two-thirds were male and two-thirds of the patients smoked. Outpatients outnumbered inpatients by almost three to one and adults and medical patients predominated over children and surgical patients.

Table 2 details the percent of patients with abnormal studies by groups. Ninety percent of all studies had some abnormality and no group tested in the laboratory had less than 80 percent abnormal. Inpatients were more likely to have abnormal tests (96.3 percent) than outpatients (87.7 percent) ($P<.03$) and a higher percent of surgical patients (95 percent) were abnormal when compared to medical patients (89.6 percent) ($P<.02$).

Twenty-eight patients had 30 normal studies (one patient had different studies performed on three separate dates). Diagnoses or indications given for the study are listed in Table 3.

DISCUSSION

There are many commonly accepted indications for pulmonary function testing: the evaluation of dyspnea; assessment for preoperative status, for disability, for the extent of lung disease as an aid in the selection of therapy and evaluation of its effectiveness, and for prognosis; evaluation of disease progression; and the monitoring of pulmonary function in workers employed in high-risk industries.[16-18] Other recommended uses of pulmonary function testing are more controversial. Although Hudgel et al.[19] have advocated mass spirometric screening to detect individuals with obvious lung disease and possibly to detect asymptomatic individuals with physiologic abnormalities, Macklem and Becklake feel this is not worthwhile.[20] Permutt advocates routine serial measurements of nearly all adult patients.[21]

Within the community, the selection of patients for referral to a pulmonary function laboratory often is variable and subjective. The purpose of this study was to assess the sensitivity of referral. Efficiency of utilization of a laboratory procedure often is determined by reviewing the percentage of abnormal studies obtained. While many negative (normal) studies may be worthwhile and useful, and some positive (abnormal) results may add nothing to patient care, a high percentage of abnormal tests usually suggests adequate sensitivity in selecting patients for testing. When the percent abnormal is very low, the cost effectiveness of the selection process is questioned. Too high a percent abnormal suggests that too few patients are being tested (some patients whose tests would be abnormal are being missed). The proper percentage that should be abnormal depends on the cost of the procedure, the potential benefit of finding an abnormality, and the invasiveness of the procedure.

Farnsworth et al. evaluated the routine use of preoperative chest roentgenographs in children.[5] Although 31 of 350 children (8.9 percent) were abnormal, 25 instances of abnormality would have been indicated from history or physical examination. Only 1 of the other 6 patients had a finding of consequence; therefore, the authors do not recommend

routine preoperative chest films for infants and children because of this low yield (i.e. 0.3 percent). Similarly, Bonebrake et al. found the yield of routine prenatal chest roentgenographs (0.4 percent) did not warrant their performance.[6] Alternatively, Sane et al. justified routine preoperative chest roentgenograms in children by finding 7.5 percent of 1,500 children (4.7 percent unsuspected) abnormal[22] and Fink et al. justified routine admission roentgenograms in a Veterans Administration population by finding abnormalities in 46 percent of 113 patients.[23]

Although Robbins and Rose found that all of the 11 percent of patients with an elevated partial thromboplastin time had a predictable risk factor, they appeared reluctant to advocate the elimination of a simple, inexpensive screening procedure in the face of the current litigatory state of medical practice.[7] In the otherwise healthy preoperative patient, Robbins and Mushlin advocate routine hematocrit (1.0 percent anemia), urine analysis (0.001 percent nephrotic syndrome and 1.4 percent urinary tract infection), and pregnancy test (1.1 percent of women of child-bearing age).[24] They list the following tests to be considered, but of "uncertain value" in the asymptomatic preoperative candidate: electrocardiogram (0.5 percent ischemic heart disease and 0.5 percent arrhythmias); BUN or creatinine (chronic nephritis 0.03 percent); serum glucose (0.29 percent diabetes mellitus); SGOT (0.025 percent hepatitis); PPD (0.045 percent tuberculosis); and platelet count (0.005 percent thrombocytopenia).

The present study found 90 percent of all patients receiving pulmonary function tests to be abnormal. This suggests that there is a large pool of patients with pulmonary function impairment who are not being tested. An alternate explanation is that a random population would have a similarly high percent interpreted as abnormal. This is unlikely as the predicted formulas used were based on asymptomatic populations. In earlier studies on asymptomatic populations, Kory diagnosed 1.9 percent to have chronic obstructive lung disease[25] and Vedal et al. identified 10 to 24 percent as being abnormal depending upon how many tests were performed.[26] While we assume that most or all of the abnormal studies were indicated (by virtue of their abnormality), it should be pointed out that most or all of the 30 normal studies (Table 3) were justified.

Patients of nonpulmonary internists were more likely to have abnormal pulmonary function tests (92.5 percent versus 82.5 percent) even though a smaller proportion of their practice is apt to be made up of patients with diseases of the respiratory system (13.5 percent versus 37.8 percent), suggesting that the pulmonary physician is more attuned to ordering pulmonary function tests.[27]

Detection of pulmonary function abnormalities may be useful in predicting postoperative problems. Stein et al. performed pulmonary function tests on 63 randomly selected preoperative patients.[28] Studies were abnormal in 30 patients (47.6 percent). Seventy percent of the abnormal group had complications as compared to 3.0 percent in the normal group. In the present study, 94.4 percent of preoperative studies were abnormal. Even with the assumption that some of the other preoperative patients had previous pulmonary function tests or went unidentified to us among the other patients in this study, it must be assumed that many patients went to surgery with unrecognized pulmonary function abnormalities (as 90 percent of all tests were abnormal).

The data suggest that the threshold for suspecting lung disease and obtaining pulmonary function studies is too high. While not advocating routine pulmonary function studies on all patients, it has been pointed out that much lower yields may be considered acceptable to justify the continued use of other routine studies. Routine hematocrit and urinalysis in the otherwise asymptomatic preoperative patient may yield positive results in 1.0 percent and less than 1.0 percent, respectively.[24] A set of pulmonary function tests, however, can cost a great deal more—10 to 30 times—than either a hematocrit or a urinalysis. Thus, a higher diagnostic yield (greater percentage of abnormal studies) and/or a significant benefit to those found to be abnormal should be demonstrated to justify these tests. If a yield of 1.0 percent abnormal can justify an inexpensive test ($10 to $25), then a yield 30 times as great, 15.0 percent, should justify a study up to 15 times as expensive ($50 to $150). A yield of 90 percent abnormal studies infers that a great number of untested patients would have abnormal results if tested.

When does identification of abnormalities benefit the patient? It already has been mentioned that incidence of postoperative pulmonary morbidity may be related to abnormal tests.[28] Such abnormalities may justify respiratory therapy interventions that significantly can decrease postoperative complications.[29] In the nonsurgical patient, it may be argued that confirming a pulmonary function abnormality the physician already suspects, adds nothing to that patient's care. In fact, the physical assessment of the patient may be quantitatively very inaccurate. McFadden et al. found that acute asthmatics became asymptomatic when lung function was 40 to 50 percent of normal and that physical signs of asthma disappeared when lung function was 60 to 70 percent of predicted.[30] Thus, even when lung disease is suspected on clinical grounds, rational management dictates the use of pulmonary tests to ascertain responsiveness to therapy as well as monitoring its effectiveness. Decisions on the need and efficacy of adding new medications to an established regimen best can be made by observing results of therapy in a quantitative fashion. Lastly, the fair and equitable determination of pulmonary disability demands a quantitative analysis of lung function.

"Patients of nonpulmonary internists were more likely to have abnormal pulmonary function tests even though a smaller proportion of their practice is apt to be made up of patients with diseases of the respiratory system."

CONCLUSION

We have found a strikingly high percentage of abnormal studies among patients sent to our laboratory for study. We conclude that the present clinical sensitivity for performing such tests is too low and recommend a closer following of already identified indications for pulmonary function testing.

SUMMARY

The results of pulmonary function tests of 300 consecutive patients were reviewed. Ninety percent of all tests were abnormal, including 96.3 percent of inpatients, 87.7 percent of outpatients, 89.6 percent of medical patients, 95.0 percent

of surgical patients, and 94.4 percent of preoperative studies. Inpatients were more likely to have abnormal tests than outpatients ($p < .03$) and surgical patients were more likely to have abnormal tests than medical patients ($p < .02$).

The low percentage of normal studies suggests that a large group of patients, including preoperative patients, who would have abnormal pulmonary function tests are not being identified and that the clinical process of selection of patients for pulmonary function testing is too insensitive.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when the use are secondary to androgen deficiency. 3 Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D., I. B. Spathopoulos, M.D. : Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Surgical Treatment of Ulcerative Colitis

LEROY H. STAHLGREN, M.D., Livingston*

Alternatives to proctocolectomy have been developed in an effort to avoid permanent ileostomy and an external appliance in the surgical treatment of ulcerative colitis. Alternatives include colectomy and ileorectal anastomosis, continent ileostomy, and mucosal proctectomy with ileal pouch and ileoanal pullthrough. The latter procedure is most promising since rectal continence and elimination are preserved.

The standard surgical treatment of ulcerative colitis has been proctocolectomy and permanent ileostomy, a reasonable approach when one considers that it has resulted in the cure of many patients with inflammatory bowel disease. With the development of modern enterostomal techniques, most patients have adjusted remarkably well to the change in lifestyle necessitated by the ileostomy and appliance. Nevertheless, to spare patients lifelong reliance on an external stoma and appliance, surgeons have sought alternatives to ileostomy.

The modern or traditional era of operative treatment was ushered in by Brooke with publication of a technique of mucosal eversion of the ileostomy.[5] The Brooke ileostomy reduced the incidence of stomal malfunction to acceptable levels. Additional technical refinements reduced the incidence of postoperative complications, i.e. the demonstration that resection of the rectum, when properly performed, did not disturb bladder or sex function.[16,17]

Among various alternatives to permanent ileostomy, considerable clinical experience has been reported with colectomy and ileorectal anastomosis,[1] continent ileostomy,[10] and mucosal proctectomy and ileoanal pullthrough.[15] More recently, a promising approach has been described by Parks in which an ileal pouch is combined with mucosal proctectomy and ileoanal pullthrough.[13]

Each of the alternatives will be discussed briefly.

ILEORECTAL ANASTOMOSIS

In a review of 300 patients upon whom he had performed total abdominal colectomy and ileorectal anastomosis for ulcerative colitis, Aylett reported satisfactory results in 83 percent of patients and failure leading to conversion to ileostomy in only 5 percent of patients.[2] It is not surprising, however, that many of his patients reported rectal dysfunction manifested by frequent stools and a sense of urgency, since the distal colon and rectum usually are the earliest and most severely affected by the inflammatory process. A further cause for concern is the risk of cancer. Baker and Aylett calculate the risk of rectal carcinoma to be 6 percent after 20 years and 15 percent after 30 years, postoperatively.[3] For these reasons, Aylett's procedure has not gained general acceptance, particularly among American surgeons.

Considering the problems associated with ileorectal anastomosis, Jones proposed criteria to limit the selection of patients to include the presence of only minimal rectal inflammation and the persistence of supple rectal walls.[9] He

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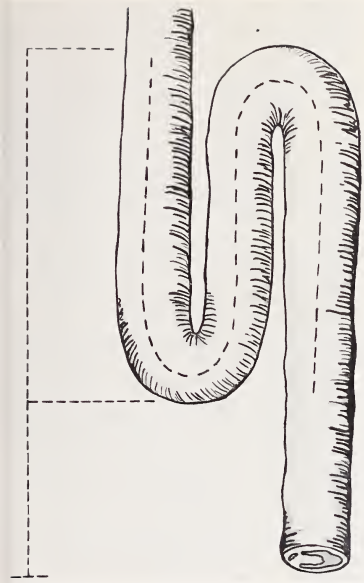


Figure 1—Reservoir created from terminal ileum. Dotted lines indicate incision line.

restricted the operation to patients in the older age groups. Jones estimated that fewer than 10 percent of patients with ulcerative colitis will meet the criteria. My experience suggests that candidates for that approach will be encountered rarely.

CONTINENT ILEOSTOMY

Kock introduced the concept of an internal ileal reservoir to eliminate the need for an external appliance.[10] To establish continence of the reservoir, he created a nipple valve consisting of intussuscepted ileum that exited through the abdominal wall. Patients evacuated the pouch by catheter every four to six hours.

The great majority of patients who undergo conversion from standard to continent ileostomy are satisfied.[6] They report improvement in body image and other emotional parameters. Sexual embarrassment is reduced or eliminated.

The major disadvantage to the procedure is the high rate of postoperative complications.[6,11] Most complications are mechanical in nature and involve the nipple valve. Kock reported valve complications leading to reoperation in 32 percent of patients and resection of the pouch in 4 percent of patients in his series.[11] Techniques in current use materially may reduce the risk; in Kock's most recent 35 patients, the complication rate fell to 6 percent.

Pouch perforation leading to peritonitis or abscess was encountered in 7 of 62 patients reported by Goligher.[8] He recommended resection of the pouch in that circumstance.

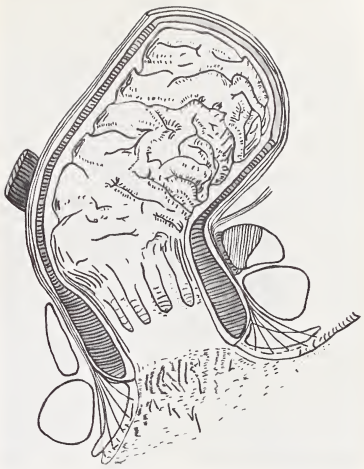


Figure 2—Anatomic sketch demonstrating rectal muscle sheath, mucosa, and anal sphincters.

Beart noted a reduction in complication rate from 42 to 22 percent when comparing the last 149 patients with the first 150 patients in his series.[4] Obviously, skill in construction of the pouch and nipple valve improves with experience. The occasional operator who has little opportunity to gain experience with the procedure would do well to restrain himself.

Inflammation of the pouch (mucosal enteritis or "pouchitis") has been described in 15 to 43 percent of patients.[10] Bacterial proliferation occurs in the presence of stasis leading to systemic symptoms and to pouch malfunction. The infection usually responds to antibiotics, particularly to agents effective against anaerobic organisms. An unusually severe infection occurring as a result of stagnation may lead to necrosis and loss of the pouch.

In deciding upon a role for continent ileostomy, one must consider both the high complication rate, and the high degree of patient satisfaction. In my view, continent ileostomy should be recommended only in those young patients who already have undergone proctocolectomy and, hence, are not candidates for a rectum-preserving operation and who cannot or will not tolerate traditional ileostomy.

MUCOSAL PROCTECTOMY AND ILEOANAL PULLTHROUGH

It has been known for 35 years that ulcerative colitis could be cured by colectomy and excision of the rectal mucosa because the inflammation spares the deeper layers of the rectal wall.[15] Of equal importance was Ravitch's finding that rectal continence was preserved when the ileum was drawn through the rectal muscle sheath and anorectal sphincters. His findings, confirmed by other investigators, disproved a theory long held that the rectal mucosa contained vital receptor sites of the sensory pathways governing continence

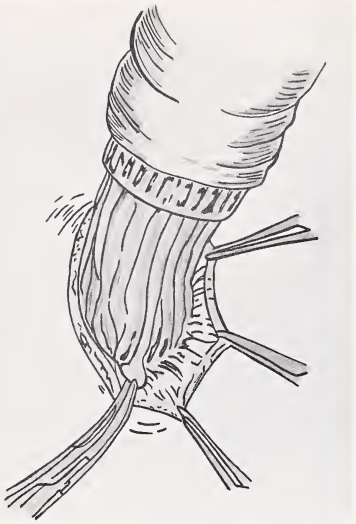


Figure 3—Dissection of rectal mucosa from underlying muscle layer.

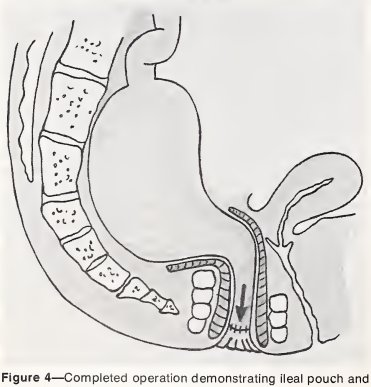


Figure 4—Completed operation demonstrating ileal pouch and ileoanal pullthrough.

and elimination. It is clear that sensory stimuli sufficient to initiate normal rectal function reside in the levator muscles and other perirectal tissues.

Ravitch's important contributions presaged techniques that have attained considerable current interest. His procedure, as originally proposed, is in limited use because of symptoms arising from partial obstruction of the ileum induced by the anal sphincters. Accommodation to relative obstruction of ileal propulsive contractions requires a long period of abdominal cramping, urgency, and frequent stools. Except in children, who adjust in a matter of months, too much discomfort and inconvenience are produced over too long a period to recommend this approach in adults.[12]

Combining Ravitch's and Kock's contributions, Parks constructed an ileal pouch and delivered its distal end through the rectum to the anal margin after excising the rectal mucosa (Figures 1 to 4).[13,14] Parks reported continence in all but a rare patient in his series of 60 patients. Approximately half of his patients experience normal elimination of 3 to 4 stools daily. The remainder catheterize the pouch intermittently through the rectum. Fonkalsrud reported continence and normal elimination in each of 5 patients undergoing a similar procedure.[7] Our experience with 8 patients, although too early to evaluate definitively, is most encouraging.

"It has been known for 35 years that ulcerative colitis could be cured by colectomy and excision of the rectal mucosa because the inflammation spares the deeper layers of the rectal wall."

The operation is performed in two stages in patients with acute ulcerative colitis or in one stage in patients with quiescent ulcerative colitis or familial polyposis. In both circumstances, a temporary loop ileostomy is created to divert intestinal content away from the pelvic dissection during the early postoperative period. The ileostomy is closed in approximately six weeks.

As in other pouch procedures, patients with Crohn's disease should be excluded. Another contraindication is extensive damage to the anal sphincter mechanism, an unlikely sequela of ulcerative colitis.

CONCLUSIONS

Ileostomy and proctocolectomy have served many patients well; indeed, many patients owe their lives to traditional surgery for ulcerative colitis. Satisfaction with the results of the standard operation, however, should not limit our critical appraisal of new developments. Ulcerative colitis is a benign disease, albeit life threatening, and consideration should be given to functional results.

Current efforts to preserve rectal continence through mucosal proctectomy, construction of an ileal pouch, and ileoanal pullthrough deserve thorough exploration and trial.

The early results are most promising.

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Malignant Melanoma of the Anal Canal

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Primary malignant melanoma of the anal canal occurs infrequently; it tends to be a very aggressive tumor that spreads early and widely with an unpredictable course. If distant metastasis can be ruled out, appropriate management consists of abdominal perineal resection. If regional lymph node metastases appear in the inguinal areas, followup radical lymph node dissections should be performed. The case of a 63-year-old man with a primary melanoma of the anal canal is described. Clinical features, preoperative evaluation, operative therapy, histologic characteristics of the tumor, and prognostic factors are discussed.

Malignant melanoma of the anal canal is a rare entity. It has the worst prognosis of all tumors affecting the anal canal. This lesion frequently presents as a polypoid growth at the dentate line and for this reason it is essential that neither patients nor clinicians dismiss it as a hemorrhoid or other benign pathologic entity.

Malignant melanomas of the anal canal tend to spread widely and early. Reported cases with long-term survival did best with abdominal perineal resection. However, even with this radical operation, there is only about an 8 percent five-year survival.[1,2] The tumor tends to be resistant to radiation, chemotherapy, and immunotherapy.[1]

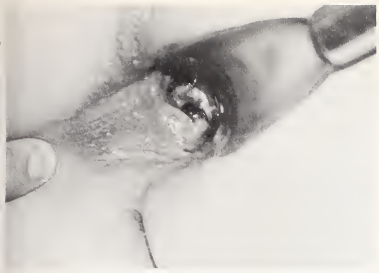
Our report describes a patient with a polypoid melanoma of the anal canal with no evidence of metastasis who was treated with an abdominal perineal resection.

CASE REPORT

A 63-year-old white male complained of intermittent, painless, bright red hematochezia. He attributed a full sensation in the anal canal to a possible hemorrhoid. He denied constipation, diarrhea, pruritus, discharge, prolapse, or weight loss. Digital examination revealed a firm nodule fixed to the wall of the anal canal in the right anterior aspect. Anoproctosigmoidoscopy revealed a polypoid lesion measuring 1.5 cm in diameter; it had a granular surface and was red with black streaks running through it (Figure). No other rectal abnormalities were found. The remainder of the physical examination was unremarkable. Biopsy of the anal tumor revealed it to be a melanoma. Hemogram, blood chemistry screen, urinalysis, chest x-ray, liver-spleen scan, and bone scan were all normal. An abdominoperineal resection with wide lymph node dissection was performed; an uneventful postoperative recovery followed.

Seven weeks after the abdominoperineal resection, the patient was found to have an enlarged lymph node in the right groin. Fine-needle aspiration cytology was performed on this lymph node and it proved to contain metastatic melanoma. Once again, an extensive search for further metastatic disease was undertaken. CAT scans of the brain, chest, abdomen, and pelvis with attention to the paraaortic and iliac lymph nodes all were negative for evidence of metastasis. The patient then was readmitted to the hospital and underwent bilateral radical inguinal lymph node dissections. All lymph nodes were negative for metastatic disease except for one superficial node in the patient's right groin. Once again, he made a smooth postoperative recovery. He was free of disease and he was asymptomatic one month following the bilateral node dissections.

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Figure—Speculum in anal canal showing polypoid malignant melanoma.

DISCUSSION

Melanoma is the most aggressive malignant tumor affecting the anorectum. It affects males and females almost equally. It is much more common in white than in black patients and the average age at diagnosis is 50 to 60 years. Fortunately, it is a rare primary tumor in this region. Only about 200 cases have been reported to date. A recent publication from Memorial Sloan-Kettering Cancer Center in New York City indicated that of 49 cases seen there during the years from 1929 to 1975, only 6 patients survived for five years or more.

The tumor arises from the transition zone between skin and mucosa of the anal canal near the dentate line. A few cases have been reported of primary melanomas arising in the rectum itself.[3,4]

Patients most frequently complain of rectal bleeding or of feeling a mass in the anal canal. The bleeding usually is small in quantity, bright red, painless, and recurrent which also is typical of hemorrhoidal bleeding. Consequently, the lesion easily may be mistaken by the patient for a hemorrhoid. Occasionally, the patient may have anal pain, prolapse, weight loss, anal irritation, or constipation.

Grossly, the tumor may appear as a small, benign-appearing nodule at the dentate line or, at the other extreme, as a large, ulcerating black mass that occludes the anus. Pigmentation may be grossly visible or identified only microscopically. The lesion may appear to be light gray to violet black.

Melanomas of the anal canal tend to spread to the rectum in the submucosa. Melanomas often invade tissue surrounding the anal canal but tend not to invade neighboring organs. Metastases may occur via both venous and lymphatic routes. Since the tumors tend to straddle the dentate line, lymphatic metastases may be upwards to superior hemorrhoidal nodes (about 70 percent of cases) or laterally to the inguinal nodes. Systemic hematogenous metastases tend to occur early and often are widespread to the liver, lung, bone, and occasionally the brain.

PATHOLOGY

Histologically, anorectal melanomas appear identical to melanomas occurring in other areas of the body. They are characterized by atypically shaped spindle, triangular, or polyhedral cells. Intranuclear vacuoles may be seen as well as multinucleated cells. The cells may be in an alveolar or haphazard arrangement and mitotic figures are seen frequently. The cells may contain melanin but often are amelanotic.[1,5]

TREATMENT

Anorectal melanoma has a reported 8 percent five-year survival rate after operation. There have been some long-term survivors reported following local excision but these were unsuspected lesions found on routine histologic examination of tissue removed by hemorrhoidectomy. In cases where the melanoma is recognized preoperatively, the only long-term survivors are those who were treated by abdominal perineal resection. As in squamous cell carcinoma of the anal canal, prophylactic lymph node dissection of the groins is not recommended. If palpable groin nodes are present, inguinal lymphadenectomy may be indicated. Melanomas of the anal canal do not respond well to radiation therapy, immunotherapy, or chemotherapy.

SUMMARY

A case of primary malignant melanoma of the anal canal has been presented. Clinical manifestations, pathologic characteristics, prognosis, and therapeutic approaches were discussed.

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Surgical Resection in Symptomatic Polycystic Liver Disease

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Surgery rarely is necessary in polycystic liver disease, but surgery was employed in two patients with large, painful intraabdominal masses that proved to be hepatic cysts. Hepatic resection was tolerated well with no postoperative complications.

Polycystic disease of the liver is due to a congenital embryological maldevelopment of the bile ducts and possible degenerative and abnormal extension of the process of resorption that causes distortion, segmentation, and dilatation of intrahepatic bile ducts.[1] Moschowitz suggested that such cysts arise from congenital obstruction of bile ducts or obstruction caused by inflammatory hyperplasia.[19] The adult autopsy incidence placed disease of the liver at 0.53 percent.[5] Polycystic liver disease is associated with polycystic changes in the kidneys or other organs; in order of frequency, these are pancreas, spleen, lung, and ovaries. The prevalence of polycystic kidneys with polycystic liver disease is 51.6 percent; polycystic kidney disease has associated cysts of the liver in 34 percent of the cases, indicating that polycystic disease of the liver is more apt to be associated with cystic disease in other organs than is polycystic kidney disease.[5,11,12,18] Cerebrovascular aneurysms have been found in a few of these patients.

Treatment is not necessary, especially in asymptomatic cysts, and surgical intervention is unusual. The following case reports refer to two individuals submitted to partial hepatectomy for control of symptoms.

CASE REPORT 1

A 56-year-old female was hospitalized with severe right upper quadrant abdominal pain and fullness in the upper abdomen. A liver scan revealed a large area of absent uptake in the right lobe and gray-scale ultrasound demonstrated multiple cystic lesions in the liver. Celiac angiogram revealed an avascular right hepatic tumor plus a left renal cyst. Preoperative laboratory studies included albumin, 4.1 gm/dl; alkaline phosphatase, 10.1 IU; bilirubin, 0.5 mg/dl; LDH, 201 IU; SGOT, 18 IU; creatinine, 0.5 mg/dl; BUN, 9 mg/dl.

Exploratory laparotomy revealed a cyst that measured 24 x 16 cm in the right hepatic lobe (Figure 1); it was excised with the gallbladder adherent to the cyst. A left hepatectomy was performed to remove multiple cysts that devitalized the lobe. Postoperative requirements were two units of whole blood and six units of albumin. The patient was discharged on the 21st postoperative day. Her condition four years after surgery is good.

CASE REPORT 2

A 77-year-old male experienced severe right upper quadrant abdominal pain for several weeks; he improved slightly with narcotic analgesics and bed rest. On physical examination, there was no jaundice but a huge, tender liver was palpable 15 cm below the right costal margin. The spleen was not enlarged. Preoperative laboratory studies included:

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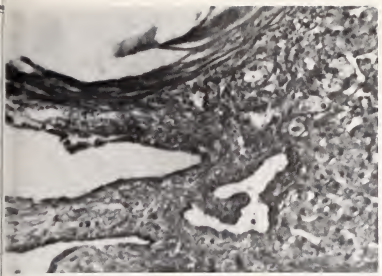


Figure 1—Microscopically, epithelial-lined, small intrahepatic cysts are seen adjacent to a larger cyst denuded of its lining and nearby normal liver tissue; H&E stain, 100 x.

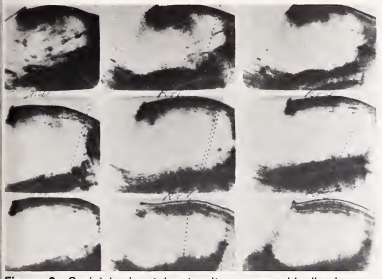


Figure 2—Serial horizontal cuts ultrasonographically demonstrate views of the huge, single right lobe cyst.

albumin, 4.1 gm/dl; alkaline phosphatase, 11.0 IU; BUN, 36 mg/dl; creatinine, 1.1 mg/dl; SGOT, 23 IU; LDH, 183 IU; prothrombin time, 100 percent preoperatively. A liver scan showed no isotope uptake in the right lobe and the liver ultrasound revealed a cystic right lobe and normal left lobe (Figure 2). A CT scan demonstrated a cystic liver; bilateral renal cysts were seen on the intravenous pyelogram.

The patient underwent exploratory laparotomy and a partial right lobectomy with drainage of two additional cysts. (Figures 3 and 4). Postoperatively, the patient had elevated liver function tests that were reduced at the time of discharge. At discharge, alkaline phosphatase was 15.8 IU; SCOT, 42 IU; and bilirubin was 1.3 mg/dl, which is normal. Intraoperatively, he was transfused with three units of whole blood and postoperatively with two units of packed cells and two units of albumin. Thirty months after discharge, the patient is clinically well with normal liver function tests.

DISCUSSION

Multiple cysts usually are present in this disease; they vary from a few to a great number that sometimes fill the abdomen and may contain as much as 1½ liters of fluid. The fluid varies from colorless to brownish in appearance. The cyst walls are composed of fibrous tissue and the lining epithelial cells range from cuboidal to flat. Compounds such as BSP and radio-labeled bile acids that are known to be secreted actively by the bile cannot be demonstrated in cyst fluid after systemic administration.[6]



Figure 3—A large right hepatic lobe cyst was excised with a portion of normal right lobe.

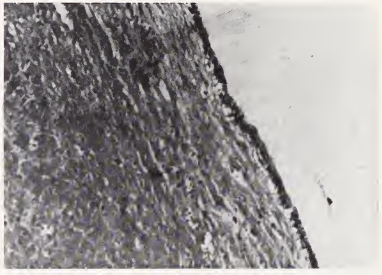


Figure 4—Microscopic exam of the epithelial-lined wall of the large intrahepatic cyst; H&E stain, 100 x.

Polycystic liver disease, detected incidentally at surgery or autopsy, usually is asymptomatic. Occasionally, the cysts may be so large that their weight or pressure on the surrounding structures will produce abdominal pain. Complications of significance include perforation, hemorrhage, inflammation, and infection.[7] Polycystic disease is difficult to diagnose on clinical grounds alone.[3]

Although jaundice is an unusual feature of polycystic liver disease, liver function tests frequently are normal.[10,11,18] Roentgenographic studies reveal pressure defects from the enlarged cysts. Intravenous pyelogram may detect cystic kidney changes and lead to investigation of the liver for the presence of cysts. Hepatic scans using radioisotopes show multiple filling defect, but do not differentiate between cysts and other space-occupying lesions.[4] Ultrasound of the liver is better than CT scan to differentiate the cystic nature of the lesions.[13,20,22]

Polycystic disease of the liver has been compatible with normal life expectancy in contradiction to polycystic renal disease that often produced renal insufficiency. The most common cause of death in patients with polycystic liver disease is renal failure due to associated polycystic disease of the kidneys. Liver failure develops rarely, but portal hypertension occurs occasionally.[4]

Several therapeutic approaches have been recommended. Cysts have been aspirated,[4,9,23] marsupialized into the abdominal cavity,[4,11,12,21,22] exteriorized,[9,21] internally drained through a Roux-en-Y,[9,16] or resected.[9,14,18,21,23] Aspiration

and unroofing into the abdominal cavity is an adequate procedure for the cysts that measure under seven cm in diameter. In the larger cysts, the devitalized wall and small portions of liver parenchyma may become foci of infection in the postoperative period. Furthermore, Wellwood et al. reported that aspiration or unroofing of cysts produced temporary symptomatic relief only.[23] Marsupialization to the exterior carries a significant danger of infection from external bacteria and also may produce a draining sinus.[21] This procedure should be reserved for cases in which the cyst contains blood or pus.[9]

Longmire et al. performed a Roux-en-Y drainage of an infected bile-containing cyst.[16] We see no indications to do this procedure in simple polycystic disease. The cyst wall is thin and friable and, therefore, an anastomosis will be very difficult. Furthermore, to construct a Roux-en-Y, two additional intestinal anastomoses are required adding to the danger of contamination and infection. Biliary cysts or fistulas do require this procedure, in which case the anastomosis will be done to the liver parenchyma or to a cyst wall that has thickened due to inflammation.

Our preference is for resection of the main cyst and any other cysts that are larger than seven cm in diameter, leaving unroofing for the smaller cysts. The amount of normal liver parenchyma that is sacrificed with this technique usually is insignificant. The liver surface after resection presented no biliary leaks or major bleeding points.

The abdomen is entered through a large right subcostal incision, which may be carried into the left subcostal area if needed. This incision has given us excellent exposure. The success of this type of surgery rests in meticulous hemostatis and the absolute familiarity with surgery of the liver. Serous drainage was profuse in the first 24 hours, but then abated rapidly.

"Occasionally, the cysts may be so large that their weight or pressure on the surrounding structures will produce abdominal pain."

Postoperative metabolic problems after extensive hepatic resection may include a progressive fall in serum albumin in the first seven to ten days with a decreased intravascular osmotic pressure. This requires an average of 175 gm of human serum albumin for ten days after surgery to support the albumin level.

Additional complications occur less frequently. The prothrombin time may fall to a level approximately 30 percent of normal but without associated clotting abnormalities that would cause bleeding. The appearance of fibrinolysins in large amounts may present problems after extensive hepatic surgery, but this is not frequent. Hypoglycemia may occur in experimental animals after extensive removal of liver tissue, but in humans this has not been a significant problem although hypoglycemic levels have been detected in occasional patients. Hyperbilirubinemia is a feature of resection and appears mainly as conjugated bilirubin. Elevated alkaline phosphatase may appear, but it clears postoperatively. This abnormality may be due to sudden congestion of the small remaining hepatic segment by portal-blood flow.[17]

Minimal bile drainage, which may be expected immediately after surgery, usually is due to inadequate ligation of large bile ducts. Biliary fistulas may occur and, if inadequately drained, bile peritonitis or abscess may complicate the picture further. Hemorrhage is the most serious complication and the most common cause of death in this procedure. A 20 percent mortality rate has been reported for hepatic lobectomy, but one reasonably should expect no more than a 5 percent mortality with this type of surgery.[17]

SUMMARY

The two patients with polycystic liver disease had indications for surgical intervention. Diagnostic studies such as radioisotopic scanning and ultrasonographic testing help pinpoint the diagnosis and direct the treatment in patients with abdominal pain and hepatic masses. To prevent multiple surgical procedures, an initial definitive approach is advisable rather than repetitive surgical efforts to decompress the cysts.

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The Subject of Impairment

DAVID I. CANAVAN, M.D., Lawrenceville*

The first article in our series described the impaired physicians movement in the United States and outlined in some detail the events in our own state that have resulted in the employment of a full-time medical director for our program.

One change that has occurred since the original article was prepared has been the sharing of the support from the Princeton Insurance Company with the Health Care Insurance Exchange. These two components of the New Jersey Hospital Association are insuring practitioners (PIC) and health care facilities (HCIE). Both recognize the benefits that an effective impaired physicians program can provide.

In this article, I would like to discuss the subject of impairment. The "impaired physician" currently is defined as "a physician whose performance as a professional person and as a practitioner of the healing arts is impaired because of alcoholism, drug abuse, mental illness, senility, or disabling disease."[1]

National statistics suggest that 10 to 15 percent of physicians are victims of impairment because of one of these conditions. It currently is estimated that 10 percent of the adult population in the United States is alcoholic. Physicians are not immune and indeed we can assume that 10 percent of our physicians are alcoholics. Drug abuse seems to affect the physician population at a greater rate than the general population. The factors that are blamed for this include:

- The unusual stresses of the premedical and medical education programs.
- The long hours and the pressures of the residency years.
- The compulsive, driving, and self-denying personality that often emerges from our system of preparation and practice.
- Physicians' intimate knowledge of mood-altering drugs.
- Increasing social acceptance of the concept of recreational use of such drugs.
- The ready accessibility of health professionals to pure, potent pharmacologic agents.

All reports on the incidence of mental illness indicate that physicians are at greater risk than the general population. This partially may be related to increased knowledge concerning mental disease and, consequently, more ready diagnosis. However, some of the same factors that play a role in drug abuse also are operative here.

Statistics on suicide indicate, once again, physicians seem to be at greater risk. In selected groups such as those who abuse alcohol and/or drugs, and especially among female physicians abusing alcohol and/or drugs, the suicide rate is higher.

Awarding the medical degree does not provide exemption from disabling illness and so a small percentage of our fellow physicians will be the victims of disability due to organic disease. I include the senile physician in this category, rather than in the classification of mental illness.

In relative incidence, the Table serves to reflect the current national experience.

There is a tendency to think of these problems as problems "someplace else." Current data on the rate of alcoholism in our 50 states indicate that New Jersey has the second highest incidence of alcoholism in its population, while California has the highest. So, we have the problem right here!

The best information I can find indicates that there are between 10,000 to 12,000 physicians actively practicing medicine in New Jersey. This means that we have somewhere between 1,000 to 1,800 impaired physicians currently in active practice in our state.

This is by no means an epidemic, but it is a realistic appraisal of what is going on. Our program represents the sincere attempt of the Medical Society of New Jersey to recognize its responsibility to the public welfare and to the welfare of our "fallen" comrades. There is a natural human tendency in the face of unpleasant reality to bury our heads

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TABLE
National Figures

	Percent
Alcohol and other mood-altering drugs	40
Alcohol	35
Drugs	10
Mental illness	10
Physical disability (including senility)	5

in the sand and pretend that these problems somehow will just go away. These problems will not go away. They will only get worse! Untreated, many of these illnesses can be fatal to their victims. We must recognize their presence in our midst and must seek effective ways to identify our stricken physicians and we must get them into appropriate therapy.

It is important to recognize that there are other categories of physicians who need to be identified and appropriately dealt with. First, there are the inept physicians. Competence in medicine is identified and defined on the basis of training, ability, and performance as judged by one's peers.[2] Most frequently, our problems are with physicians who fail to maintain their current cognitive knowledge. Appropriate educational programs that are pursued regularly are the only solution here. Disciplinary action should be reserved only for those who refuse to upgrade their knowledge and their skills.

The unethical physician is the next one who warrants attention. This is the physician who finds the fee is the prime indication for the procedure; the one who feels that all is fair if you are filling out a third-party claim form; the one whose fee scale is whatever the traffic will bear. This also is the physician who is involved in criminal activity outside his medical practice.

Thirdly, we have the immoral physician who sexually abuses or corrupts his patients. We can argue about the morality involved in sexual encounters between consenting adults, but there is no place in the consultation room or the examining room for such conduct. Moreover, the persuasive power of the role of personal physician can put patients at a real disadvantage in these co-called "acceptable" encounters.

The public has the right to expect and the Hippocratic oath demands that the physician holds himself above seduction and the leading of others into vice.

Finally, we have the prescription abusers. Some of these are themselves substance abusers and use their prescription pad as the key to the candy jar. They invariably are caught by the DEA agents because of their disproportionate prescriptions. This may be their route to our program.

The next are the ignorant physicians, those who do not know the CDS regulations and in their ignorance violate the law. These physicians need education so that they can avoid these errors.

The most serious problem in this category is with the script writers. These are the physicians whose motive is greed and will write for anything providing the fee is adequate. These physicians are not worthy of their stature and should be defrocked.

All of these physicians are indeed "impaired." Their problems need to be addressed. Throughout the country they have been separated from the province of the impaired physicians program. They must not be lost in the shuffle.

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Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physician Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately, the psychopathy of substance abuse and addiction always gets worse while it is ignored.

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Help us to help our impaired colleagues.

WHAT IS YOUR OPINION?*

ALG and PMD Syndrome

EDWARD G. BOURNS, M.D., Jamesburg**

It is four P.M. on Friday afternoon and ALG's weekly CPC is about to begin. ALG Hospital, 350 beds, is struggling to up-thrust its restructured facade and compete with the surrounding glittering symbols of MM (mechanical medicine). This miniature United Nations of factional departmental struggles is chaired by Dr. HEEP (hearing, eyes, ears, passable).

Dr. HEEP, age 69 and four years past retirement, has been given a five-year extension for his meritorious years of untiring service and possibly because his wealthy wife gave five million to the building fund. His gray sparse thatch, slight stoop, sliding bifocals, and somewhat "off there somewhere" demeanor bespoke of the years dedicated to medicine, now plagued by shedding Betz cells and creaky joints.

Assembled along with Dr. HEEP were the staff: Dr. PEEP (pursue every evasive possibility), CRIM (chief resident in medicine), Dr. CREEP (continuously reconnoiter every extraneous parameter), and ALI (a lowly intern).

Dr. HEEP: "Doctors, we have a most interesting and puzzling patient to discuss today. I'll ask Dr. PEEP to present the facts."

Dr. PEEP: "This 75 year-old DWM (disoriented white male) complains of SCP (substernal chest pain). He was sent to ALG by LMD (local M.D.) under the auspices of RMP (Regional Medical Program) and HRET (Hospital Research and Educational Trust) as provided for by HUP (Hospital Utilization Program) and approved by JCHA (Joint Commission for Hospital Accreditation). He was turned down by PSRO (AOOANOI)—(anyone of a number of intepretations). He has a bulbous rash and suffers from COPD (chronic obstructive pulmonary disease). I suspected an MI (myocardial infarct) and accordingly I submitted all salient features of his physical findings and lab results to both our EDP (electronic data processor) and our new $872,000 DPPDEF (data processing of patient diagnoses by electronic factoring) machine. It should give us a compendium of possible diagnoses. That is, provided the PD (power disconnect) of the SAS (standard alarm systems) as approved by the PAS (Professional Activities Studies) doesn't blow a gasket."

There is a great whining and whirring of tape reels, lights flash off and on, and a long tape sputters forth. Dr. PEEP picks it up and proudly presents it to Dr. HEEP.

Dr. HEEP: (puzzled): "Looks like a Chinese ticker tape to me. What's it say, PEEP?"

Dr. PEEP: "Well, sir, tape says the problem is located above the BB. Oh, yes, the umbilicus. It says the DD (differential diagnosis) lies between HH (hiatus hernia) with laxity of the GER (gastroesophageal reflex) producing pain at the LESZ (lower esophageal sphincter zone) and IRDSN (idiopathic respiratory disease of the newborn).

Dr. HEEP: "Hold it! How's that again—IRDSN in a 75-year-old male!"

Dr. PEEP: "Humm, sorry, I'll run it through again."

Dr. PEEP: "Oops, sorry sir, it came out backwards the first time. Should be NSDRI (neurological symptoms directly related to intoxication) Sometimes this $872,000 machine doesn't live up to its responsibilities."

Dr. HEEP: "You may proceed, PEEP."

Dr. PEEP: "We have some other data just appearing. These are mainly PPP (physiologic pulmonary parameters) related to PFT (pulmonary function tests). We put him on a ADV (adult volume ventilator) under IMV (intermittent mandatory ventilation) under CPAP (constant positive airway pressure) until his LV (lung volume) as calculated by LVEDP (left ventricular end diastolic pressure) extrapolated so that his VD/VT (physiologic dead space to tidal volume) related closely enough to his AS/GT (absolute shunt to cardiac output) to enable him to walk to the bathroom."

Dr. HEEP (anxious to show his savvy and with a blepharoplastic twinkle in his good eye): "What did that do to his ZEEP (zero end expiratory pressure), PEEP?"

Dr. PEEP: "Well, sir, we set the machine so that his MIPR (maximum inspiratory pressure relief) was the logarithm of his HEEP (high end expiratory pressure)—apologies to you, Dr. HEEP—until his MIE (maximum inspiratory effort) brought his SMA (never can remember this one) in line with his PSRO (SYOI—supply your own interpretation).

Dr. HEEP: "Very erudite, PEEP, what are your conclusions?

Dr. PEEP: "I think he's sick."

*We encourage our readers to write on topics of interest. Send your opinion to Editor, *The Journal,* MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

**Dr. Bourns is a retired member of our Middlesex County component.

Dr. HEEP: "Very astute. Now suppose we hear from our illustrious medical department. Dr. LIMP, will you step up?"

Dr. LIMP (let's investigate multiple possibilities):I just have completed a carefully controlled series of GRNA studies (gated radionuclide angiocardiography) as related to CAPD (continuous ambulatory peritoneal dialysis). These studies under NIH grant 27654 clearly are related to our patient's ClP (plasma clearance) and his ACEI (angiotensin converting enzyme inhibitors). We did some PTCAs."

Dr. HEEP (interrupting, chest swelling, casual pride in his voice, anxious to show his drummer was beating with contemporary rhythm): "LIMP, we all know that one—"parent teachers cooperative associations."

Dr. LIMP: "Sorry HEEP, its "percutaneous transluminal coronary angioplasty."

Dr. HEEP: "Proceed."

Dr. LIMP: "Our final diagnosis was arrived at via CCS (coordinated cardiac studies) with IMPACT (International Mexiletine Placebo Antiarrhythmic Trial) funded by Bosbringer-Ingelheim for MEHI (Multinational Evaluation of Heart Irregularities). If Dr. PEEP had consulted our POR (problem oriented record) and entered his data into our LACC (linear accelerator center converter) he could have found different results. You may recall our patient has a rash. Juxtaposition, correlation, and interpretation lead me to believe he is suffering from EBA (epidermolysis bulbosa acquisita), a noninheritable, noninflammatory, subepidermal mechanobulbous disease of adults characterized by cutaneous blisters after minor trauma. It's really rather obvious. However, my ultimate conclusion is that the man is obviously, if puzzlingly, suffering from IRP (idiopathic retroperitoneal fibrosis). My findings definitely are corroborated by recently published studies from SOAP (southwest oncological adjuvant protocol)."

Dr. HEEP: "Gadzuks, LIMP, I think you've got it! Now let's hear from our eminent friend in neurology. Dr. MATTER."

Dr. GRAY MATTER: "Gentlemen and ladies—excuse the lapse please—I am holding in my hand a simple HHPC (hand-held programmable calculator) invented by, if I may modestly say so, my brother-in-law, an ex-IRS agent (involutional revolutional subversive). It is a new instrument for digital evaluation of TENS (transcutaneous electrical nerve stimulation) and shows SPID (sum of pain intensity difference) which differentiates it from RIND (reversible ischemic neurological defects) and PRIND (potentially reversible ischemic neurological defects). It gives instantaneous nanagrams of SLH (serum luteinizing hormone) and its counterpart HPLHRH (hypothalmic peptide luteinizing hormone-releasing hormone). Incidentally, we have numerous HPLHRN studies investigating the possible relationship of it to psychogenic aberrations of marital problems."

Dr. HEEP: "Hold it a moment, MATTER, will you run that by once more or tell me what it means?"

Dr. MATTER: "Well, his wife says he's no good anymore."

Dr. HEEP: "Hmmm, well, proceed and let me know if these studies are conclusive and what the RDA (recommended daily allowance) is. What are your conclusions?"

Dr. MATTER: "I believe he is suffering from MCTD (mixed connective tissue disease) brought on by low levels of RNP (ribonuclear protein) as evidenced by ENA (extractable nuclear antigen) and aggravated by EPA imbalance."

Dr. HEEP: "Just a moment, how does the Environmental Protection Agency get in this?"

Dr. MATTER: "HEEP, that's eicosapentanoic acid, fish oil, if you please—brings down cholesterol."

Dr. HEEP: "Well, there you have it, a real cosmic Saganic revelation by our upstairs department. And now the department of Pathology's Dr. BRAIN.

Dr. BRAIN (whose motto is IAMCDIHD—if a machine can't diagnosis it, he's dead): "The problem of those of you who examine warm bodies is that you forget that we of the cold bodies have the last word. It is not without being fittingly proper that we are known as COLR (court of last resort). I shall not offend your combined sensitivities by a long discourse on the nuances of what, from lab studies, is disconcertingly obvious. If early on someone has had the perspicacity to do a simple HI (hemoagglutinatism inhibition) study and proceeded therefrom to an ELISA test (enzyme-linked immunosorbent assay) it would have been immediately obvious that a MDA (multiple daily fractionation) of a SCAT (sheep cell agglutination test) would at once place the diagnosis between SSPE (subacute sclerosing panencephalitis) and a plain deficiency of CAMP (cyclic adenosine monophosphate). Of the two, though it is a bit campy to get in a pun, I prefer to bet on the latter."

Dr. HEEP: "Well, confreres, there is another bit of deductive, or is it inductive, reasoning. We now have at least five opinions to debate. They are: 1) Dr. PEEP's statement, "He's not well."; 2) Dr. CREEP's statement, "He has wax in his ears."; 3) Dr. LIMP's statement "IRF (ideopathic retroperitoneal fibrosis)"; 4) Dr. MATTER's statement "MCTD (mixed connective tissue disease)"; and Dr. BRAIN's statement "Deficiency of CAMP (cyclic adenosine monophosphate)." Now here is the patient. What's happened to him?"

NURSE BB (buxom and beautiful): "Sir, I'm sorry, but in all the interval of waiting for the machines to make a diagnosis, the PMD syndrome supervened."

Dr. HEEP: "The PMD syndrome, what's that?"

NURSE BB: "The poor man died!"

Epilogue: For the benefit of harried authors seeking to get trendy but not tacky, the author of this paper is starting a new service, "Acronyms, Inc." This stands for: A-always, C-consider, R-rearranging, O-orderly, N-nonsense, Y-your, M-message, S-solidly, I-intellectualized, N-nominal, C-charge.

TAXING THOUGHTS

By Mark Carter Trentacoste, MBA, J.D.

Tax Traps in Leasing

Especially when individual income tax rates were as high as 70%, professionals found it extremely attractive to personally purchase equipment and other property and lease the property to their corporations. Even with combined federal and state tax rates now about the same for individuals and corporations, leasing may still be advisable for shifting income and other reasons.

However, leasing can easily become an expensive tax trap for the unwary. Depending on the length of the lease and the expenses which the lessor pays under the lease, the professional acting as a lessor may not be eligible for investment tax credit on the leased property. The lease must be carefully drafted to assure that the lessor will be entitled to the credit. An informal lease will almost certainly cause the I.R.S. to deny the credit to the lessor.

Often, however, the professional is better advised to file the necessary election to allow the lessee to claim the investment tax credit. If the lessor claims the credit and then finds it disallowed on audit it will be completely lost—the lessee will not be able to claim it.

Now that the interest rate I.R.S. can collect on tax deficiencies is well above market rates, falling into a tax trap can be an especially painful experience.

(Mr. Trentacoste formerly practiced as a CPA and is now an attorney with a general commercial practice. He welcomes the opportunity to discuss this or other issues informally or as part of a professional consultation.)

Mark Carter Trentacoste, Esq. **Moorestown, N.J.**
Old Town Hall, Suite 6 **Phone 234-5144**

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Trustees' Minutes November 21, 1982

A regular meeting of the Board of Trustees was held on Sunday, November 21, 1982, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Report of the President . . .

(1) JCAH Manual Proposed Medical Staff Revision . . . Instructed the AMA Delegation to support, if possible, the resolutions from New York and Pennsylvania:

Resolved, that the American Medical Association encourage the Joint Commission on Accreditation of Hospitals in revising the medical staff standards in the *Accreditation Manual for Hospitals* to maintain the quality assurance and credentialling functions of the organized medical staffs of accredited hospitals; and be it further

Resolved, that the American Medical Association urge the Joint Commission on Accreditation of Hospitals to send the current drafts of the revisions to the medical staff standards to each state medical society, each specialty society, and each delegate and alternate delegate for comment prior to final approval of the revisions.

(2) Statewide Peer Review Mechanism . . . Approved the establishment of a task force to study the effect of the "Peer Review Improvement Act of 1982" on New Jersey PSROs.

Report of the Executive Director . . .

(1) MSNJ 1982 Paid Membership . . . Reported a progressive increase in the total 1982 paid membership since October 31, 1982. Noted that total paid membership is expected to exceed the formal budget projection.

(2) Counties Exceeding 1981 Paid Memberships . . . Noted that seven counties have exceeded their paid memberships reported at this point in 1981: Atlantic (2), Hunterdon (2), Middlesex (11), Morris (2), Passaic (4), Sussex (4), and Union (19).

(3) Commissioner of Health . . . Noted that ten candidates are being considered for the position of Commissioner of Health and the bill **(S-1841-Codey)** that eliminates the requirement that the Commissioner of Health be a physician is being studied.

(4) Proposed 1982-1987 State Health Plan . . . Noted that no final action was taken on the proposed State Health Plan at the November meeting of the Statewide Health Coordinating Council.

(5) Professional Liability Rates and Classification Changes . . . Noted that overall rates for professional liability will remain the same for policy year 1983 as they were for policy year 1982. Noted that the Board of Governors of the Medical Inter-Insurance Exchange of New Jersey has approved a number of changes in rate classifications; a newsletter announcing the changes is being mailed by MIIENJ.

(6) Legal Matters . . .

(a) Peer Review under FTC Order . . . Noted that Mr. Maressa will advise the Judicial Council to inform all judicial committees to continue conducting inquiries on complaints, hearings, and adjudications involving specific fee questions between individual patients and physician members, and insurance carriers and physician members.

(b) Subordinated Loan Deductibility . . . Reported that the litigation involving the deductibility of subordinated loan monies now is in the process of argument before the Tax Court.

(c) State Board of Medical Examiners vs. Greco . . . Noted that the doctor was found guilty of gross neglect in connection with two patients and not guilty of the charge in four other cases; the judge recommended suspension of the doctor's license, and that he be placed on probation and allowed to practice.

(7) Legislation (A-721-Gormley) . . . Suggested that local assemblymen be contacted and urged to support this bill that states decisions of the Administrative Law Judge would be appealable directly to the Appellate Division of the Superior Court.

(8) Appointments to the State Board of Medical Examiners . . . Noted Governor Kean's appointments to the State Board of Medical Examiners: Abdol H. Islami, M.D., Edward W. Luka, M.D., Floyd J. Donahue, M.D., Mr. Nicholas Sidoti, Joseph A. Riggs, M.D., and Edwin H. Albano, M.D.

(9) Medical Surgical Plan of NJ . . .

(a) Service Benefits . . . Voted to submit a formal complaint to the Commissioner of Insurance concerning the denial of major medical claims of participating physicians under Blue Shield contracts when patients are eligible for service benefits.

(b) Rehabilitation Treatment . . . Concluded that MSNJ has taken whatever steps are feasible to achieve adequate coverage for rehabilitation treatment; it was noted that most major medical carriers cover rehabilitation treatment the same as any other treatment.

(10) Membership Directory . . . Directed staff to inform the county societies that members who have not sent in their verification forms for the 1983 *Membership Directory* will have a two-week extension from the date of notification to respond; if no response is received, the information in the 1981 *Membership Directory* will be listed with a footnote stating that the information was not verified.

Impaired Physicians Program . . . Received a written report on the activities of the Impaired Physicians Program from David I. Canavan, M.D., highlighting the following items: 1) active caseload of 34; 2) meeting with Edwin H. Albano, M.D., President of the State Board of Medical Examiners, and Joan Gelber, Deputy Attorney General; and 3) notification that the Board of Trustees of the Princeton Insurance Company and the Board of Trustees of

the Health Care Insurance Exchange have approved grants of $25,000 per year, for three years, to the Impaired Physicians Program.

University of Medicine and Dentistry . . . Loan Default . . . Directed the executive staff to work with Stanley S. Bergen, Jr., M.D., President, UMDNJ, to determine if there are any members of MSNJ who are in default of their loans at UMDNJ with the understanding that an appropriate action would be taken by the Board in connection with members so involved.

Note: UMDNJ is faced with the withdrawal of federal monies if the default rate on present loans is not less than 5 percent; the default rate currently is 11 percent.

New Jersey Hospital Association . . .
(1) Child Abuse Seminar Cosponsored by MSNJ . . . Noted two seminars on December 2 and 8, 1982, dealing with the sensitive and difficult issues that hospital personnel and physicians face in the hospital setting and the clinical and social issues of child abuse.

(2) Advisory Committee Completes Charge . . . Noted that a working committee of the New Jersey Hospital Association established criteria that would be acceptable to hospitals, PSROs, and Medicaid was sent to the Division of Medical Assistance of the Department of Human Services. Noted that emergency room reviews was another topic considered by this committee.

(3) Withdrawing of Life-sustaining Procedures for the Terminally Ill . . . Approved the following recommendation:

That a cooperative approach to examining these bills and the issues raised be encouraged.

Note: MSNJ has approved **A-131-Weidel** (Withholding or Withdrawing of Life-sustaining Procedures in the Event of Terminal Illness) and **A-1099-Hermon** (Consent for Medical Treatment) and has disapproved **S-1348-Russo** (Discontinuance of Medical Treatment). No action has been taken on **A-1866-Markert** (Life Decision Act).

(4) S-1841-Codey (Commissioner of Health) . . . Noted that the Board of Trustees of the Hospital Association unanimously voted to support this bill. Indicated the Board's disapproval of the action taken by the Hospital Association.

Council on Mental Health . . .
(1) Insurance Coverage for Psychiatric Services by Third-Party Payers . . . Approved the following recommendation with the understanding that the proposed legislation will be presented to the Board for final approval:

That the Board of Trustees support and seek a legislative mandate which treats psychiatric illnesses as other diseases and provides for equal insurance coverage.

(2) Guidelines for Accreditation of State Psychiatric Hospitals . . . Agreed to adopt the medical staff model and instructed the AMA Delegation to support, if possible, the resolutions of the Pennsylvania and New York Delega-

217th Annual Meeting
April 29–May 2, 1983

Resorts International
Atlantic City, New Jersey

Daily Schedule

Friday, April 29, 1983
3:30 p.m.—Board of Trustees' Meeting
5:00 p.m.—Delegate Registration
7:00 p.m.—Officers' Cocktail Reception followed by Dinner

Saturday, April 30, 1983
7:30 a.m.—Delegate Registration
9:00 a.m.—House of Delegates
9:00 a.m.—Message Center, Scientific, Informational, and Insurance Exhibits Open
10:30 a.m.—House of Delegates (election)
12:00 noon—Golden Merit Award Ceremony followed by Reception
1:00 p.m.—Reference Committee Meetings
5:00 p.m.—JEMPAC Political Forum
5:45 p.m.—JEMPAC Wine and Cheese Reception

Sunday, May 1, 1983
8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—Scientific Sessions
12:00 noon—Luncheons
1:00 p.m.—Scientific Sessions
6:30 p.m.—Inaugural Reception followed by Inaugural Dinner

Monday, May 2, 1983
6:30 a.m.—County Society Breakfast Caucuses
8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—House of Delegates
12:00 noon—Message Center, Scientific, Informational, and Insurance Exhibits Close
12:00 noon—House Adjourns for Lunch
1:30 p.m.—House Reconvenes
3:00 p.m.—Board of Trustees' Meeting

tions (see resolutions under Report of the President.)

Council on Public Relations . . .
Continuing Projects for 1982-1983 . . . Approved the following items as continuing projects: publication and distribution of the *Membership Newsletter,* as required; preparation and publication of special news releases and publicity, as required; responsibility for bestowal of the Golden Merit Award; responsibility for issuance of press releases at the annual meeting; encouragement of continuance or establishment of orientation programs for new members under the sponsorship of component societies; encouragement of increased voluntary blood donations; encouragement of radio broadcasts under the auspices of component medical societies; encouragement of medical television programs; diabetes detection week; placement service in *The Journal;* and coordinate efforts with the Ad Hoc Committee on Drug and Alcohol Abuse for drug abuse education and prevention. Noted the approval of the following recommendations concerning the continuing projects for 1982-1983:

That the Medical Society of New Jersey honor its Fellows by awarding them a medallion in addition to the Fellow's key they now receive.

That the Medical Society of New Jersey investigate methods to intensify media coverage at the annual meeting.

That the Board of Trustees encourage each component society to establish a recruitment and orientation program for new members.

That the Board of Trustees approve a media techniques seminar to be sponsored by the Medical Society of New Jersey and held at the Executive Offices in the spring of 1983.

Committee on Emergency Medical Care . . . Approved the following recommendation:

That the Board of Trustees inform the New Jersey Department of Transportation and the State Board of Medical Examiners that the Medical Society of New Jersey is opposed to signs being placed along the highways for any emergency medical care center that is not open 24 hours a day, seven days a week.

Old Business . . .
Resolution #18—Monosodium Glutamate . . . Filed correspondence from the Acting Commissioner of Health stating that he does not endorse making Resolution #18 a regulation since data are only able to document a very few foodborne incidents due to MSG.

New Business . . .
(1) AMA Delegate Allocation for 1983 . . . Referred to the Nominating Committee information from the American Medical Association. Noted that New Jersey will increase its number of AMA delegates to eight and is 92 members short of a ninth delegate and asked component societies to increase their efforts to obtain additional AMA members.

(2) Appointment of a Limited Guardian for Certain Persons Exposed to Coercive Persuasion . . . Referred to the Council on Mental Health for review, bills **S-488** and **A-1087;** these bills provide for the appointment of a limited guardian for a person 18 years of age or older who has undergone psychological deterioration to the point that he/she lacks the capacity to make independent and informed judgments or to understand or control his/her behavior as a result of being subjected to coercive persuasion by a group that has misled or could be expected to have misled the person as to the group's identity or practices.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

With 37 infant deaths per 1,000 births, the city of Camden's infant mortality rate was nearly three times greater than the state rate and the highest of any other city or county. In addition, city rates significantly topped other state statistics in deaths due to cancer, heart disease, cerebrovascular diseases, and accidents. And, of 20 tracts in the county, 9 tracts were designated as health-manpower shortage areas by the federal government. It was estimated that from 20,000 to 30,000 persons in the area medically are underserved. Such was the bleak picture of health care in South Jersey in the last decade.

This was the challenge that faced the University of Medicine and Dentistry of New Jersey when it began its first Area Health Education Center (AHEC) programs in 1980. Supported by $8 million in federal and state aid, UMDNJ had the clear mandate of broadly upgrading the health care system of the greater Camden area.

Since then, marked improvements have been achieved. Among them, a 20 percent rise in primary care physicians in Camden County: an increase in dentists, allied health professionals, and nurses; the sponsorship of more than 50 specialized health education programs. Further, local health clinics were started and expanded to bring primary care to citizens who never had it before on a consistent, ongoing basis.

Now, this massive commitment is being expanded to all of South Jersey through an additional $3 million in aid from federal, state, and local sources. The new effort will create the Shore and Garden Regional AHECs, which comprise seven southern counties.

Our Camden-based UMDNJ-New Jersey School of Osteopathic Medicine, administrator of AHEC programs, deserves much credit for the exceptional handling of this complex and worthwhile effort. Already, AHEC involves a network of 52 New Jersey and Philadelphia health care providers, educational institutions, and community organizations and UMDNJ's schools of medicine, dentistry, and health-related professions.

In another area of achievement, faculty at UMDNJ-Rutgers Medical School have developed a new, painless technique that may simplify the diagnosis of heart disease. John B. Kostis, M.D., Professor of Medicine and Chief of Cardiology at the Piscataway campus, and John L. Semmlow, Ph.D., Associate Professor of Electrical Engineering at Rutgers University and Associate Professor of Surgery (bioengineering) at UMDNJ-Rutgers Medical School, have successfully tested a computerized, electronic system that amplifies and analyzes the sound of blood flowing through the coronary arteries. This new system—that was explained recently in a paper at the American Heart Association's annual meeting in Dallas—allows the physician to detect faint changes in the sound of blood flowing through narrowed coronary arteries.

The new technique measures the silent intervals between heart beats. Recorded sound waves are amplified and fed into a computer which analyzes the information to produce sound waves representing blood flowing through the vessels. The picture then reflects changes in blood flow created by arterial narrowing.

IBM Biomedical Systems of Princeton has awarded a grant to the researchers for further development of the procedure. The researchers believe that the new procedure could replace the need for invasive tests, like angiography, in many cases.

UMDNJ took an important step toward understanding and treating the compulsive gambler during a recent one-day seminar. Perhaps some of you attended our Gambling Symposium at UMDNJ-Rutgers Medical School which involved a broad spectrum of information provided by physicians, psychologists, and representatives of the gambling industry, the National Council on Compulsive Gambling, and the Veterans Administration.

MSNJ Auxiliary

Linda B. Hirsch
President

Drunk drivers are involved in most serious or fatal automobile accidents in New Jersey. Support of stringent anti-drunk driving laws can help reduce these shocking statistics.

In October, 1982, President Reagan signed a law providing incentive grants of $720,000 annually for three years to states whose antidrunk-driving statutes meet its minimum requirements. State law must specify that a person with a blood alcohol level of 0.10 percent is guilty of driving while intoxicated. A three-day minimum jail term must be imposed for a second violation. If state law allows impounding of a convicted person's vehicle for the term of license suspension and other terms, an additional $480,000 annually is available. Grants are to be used for highway safety programs aimed at drunk drivers.

Recently, the New Jersey Senate Law, Public Safety, and Defense Committee released Senate Bill S-1833 which would amend New Jersey drunk driving laws in compliance with the federal legislation. New Jersey motor vehicle officials plan to use the federal grant to aid in apprehending and educating drunk drivers. More communities will be given funds to pay for overtime drunk driving police patrols.

Auxiliary members of the Medical Society of New Jersey are being asked to support Senate Bill S-1833, which is sponsored by Senator Frank Graves (Passaic). The Medical Society of New Jersey Auxiliary Mental Health Committee Chairman, Ida Kovacs, has requested that county medical society auxiliaries sponsor educational programs on the dangers of drinking and driving. Physician support of Senate Bill S-1833 and of auxiliary programs can be effective in reducing highway tragedies.

But Doctor, I Need . . .

Lucius A. Bowser, R.P.*

Scenario: It is just before closing of office hours and in comes a male, approximately 22 years of age, rather well dressed. The person is new to the office and asks to see the physician. The nurse asks what is the trouble. He replies, "I have severe pains going through my groin and up the back. I am in great pain." A card is prepared with the patient's name, address, and telephone number. The physician hears the tale of pain, and then asks for a urine sample. The young man goes into the laboratory, pricks his finger, drops a small globule of blood into the urine and returns for further diagnosis. He tells the doctor, "I have had this pain for a few days, but my regular doctor is out of town. The pain is excruciating and he told me it might be a stone." The doctor answers, "I think you need a complete examination, and you will have to come back in the morning." The patient responds, "But doctor, the pain is so bad. I need something for it now." The doctor, "I'll write you a prescription for Darvon Compound® to hold you until tomorrow." The patient: "I am allergic to the aspirin in it." The doctor, "How about Talwin®?" The patient, "No, that makes me nauseous. Doctor, I need Dilaudid®." The doctor, "Okay. Here is a script for 12 tablets. See you tomorrow." And nevermore shall the patient be seen.

Does this scenario sound familiar? Has it happened to you recently? Such occurrences happen almost daily, and another physician is taken for an illegal prescription for Dilaudid®, a very potent narcotic drug.

A similar situation occurs with a person allegedly suffering from an abscess in the mouth who convinces the medical practitioner that he/she is undergoing root canal work by an orthodontist who happens to be out that day. The suggestion to take an antibiotic to reduce the swelling (which has been caused by self-inflicted jabs with a paper clip), brings the immediate response that the person is allergic to the antibiotics. When other suggestions are made, all types of reasons are offered and then the real statement comes out, "Doctor, I need Dilaudid®, Percodan®, Demerol®."

Physicians must determine when medication is justified for each individual situation. The decision should be made after a thorough history and physical examination and the diagnosis has been considered thoroughly. What medication is required, should be the physician's choice. Never let the patient dictate which drug you prescribe. Such a demand should alert you that something is wrong.

Once such a drug request has been honored, the patient passes the word around. Shortly, others will appear with similar feigned illnesses. Narcotic dependent individuals are skilled at feigning all known symptoms associated with sciatica, gallstone, urinary infections, and other medical problems where the prescription of narcotic drugs may be appropriate.

The physician should contact local authorities after such an experience to help with the apprehension of the individual. Passing the word to others in the same field immediately might alert others of the modus operandi.

Many physicians are victims of such deception. With the increase in heroin use and the increase in controlled dangerous substances abuse, deception to obtain lawfully prescribed drugs also is increasing. Many times, the drugs obtained are not being used by the persons getting the prescription but are being sold on the street. (Dilaudid® has sold for as much as $20 to $25 per tablet.)

Physicians must control the patient interview and diagnosis.

"But doctor, what I need is," should end with "What I, the doctor, think you ought to have for this condition."

Can you make that decision?

*Mr. Bowser is Chief, Drug Control Program, New Jersey State Department of Health, Trenton, NJ 08625.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Bert Guajardo, M.D., 7907 Belle Park Dr., Houston, TX 77072. Creighton 1979. Board eligible. Group or partnership. Available.

CARDIOLOGY—Jared M. Insel, M.D., 414 Fellows Avenue, Syracuse, NY 13210. NYU 1977. Board certified. Group, partnership, solo. Available July 1983.

FAMILY MEDICINE—Daniel J. Sastic, M.D., 9 Farragut Drive, Piscataway, NJ 08854. Rochester 1980. Board eligible. Group or partnership. Available June 1983.

David Kaufman, M.D., 70 Lancaster Rd., West Hartford, CT 06119. St. Louis 1975. Board certified. Partnership or group. Available July 1983.

Max Burger, M.D., 11 West 69th St., New York, NY 10023. Royal College of Surgeons (Ireland) 1976. Board certified. Group, HMO, partnership. Available February 1983.

GASTROENTEROLOGY—William W. Mark, Jr., M.D., 2289 South Lewiston St., Aurora, CO 80013. Guadalajara (Mexico) 1975. Also, general internal medicine. Group or partnership. Available June 1983.

Leonard Luterman, M.D., 5740 Cavendish Blvd., Apt. 1308, Montreal, Quebec, Canada H4W 2T8. McGill 1977. Also, general internal medicine. Board eligible. Any type practice. Available July 1983.

Louis D. May, M.D., 2122 Kensington Ave., Salt Lake City, UT 84108. Miami 1978. Also, general internal medicine. Board certified (IM). Group or partnership. Available June 1983.

Satya V. Jayanty, M.D., 131 Breckinridge Square, Louisville, KY 40220. Andhra (India) 1974. Also, general internal medicine. Board certified (IM). Partnership. Available July 1983.

GENERAL PRACTICE—Alan D. Brownfield Palo, M.D., 6611 Pelham Dr., Parma, OH 44129. Guadalajara (Mexico) 1976. Special interest in ENT. Office-based general ENT, surgical ER, surgical house staff. Available.

Jayen C. Shah, M.D., 4848 North Kimball, Apt. 2-N, Chicago, IL 60625. Baroda (India) 1974. Also, emergency room medicine. Group, partnership, solo, employment. Available.

HEMATOLOGY (PEDIATRIC)—Shailesh J. Shah, M.D., 430 E. 67th St., Apt. 5-C, New York, NY 10021. Baroda (India) 1974. Special interest in pediatrics, and pediatric oncology. Group, partnership, institutional. Available July 1983.

INTERNAL MEDICINE—Curtis A. Wushensky, M.D., 3437 Fifth Ave., Apt. 506, Pittsburgh, PA 15213. University of Pittsburgh 1979. Board eligible. Salaried, hospital, locum tenens, emergency room. Available.

Ellis R. Levin, M.D., 223 Pacific St., Apt. D, Santa Monica, CA 90405. Jefferson 1975. Subspecialty, endocrinology. Board certified. Group, associate, partnership. Available.

B. Sathish Chandar, M.D., 150 York St., Stoughton, MA 02072. Stanley (Madras, India) 1975. Board eligible. Partnership. Available.

William W. Mark, Jr., M.D., 2289 South Lewiston St., Aurora, CO 80013. Guadalajara (Mexico) 1975. Subspecialty, gastroenterology. Group or partnership. Available June 1983.

Laurence N. Sechter, M.D., 1870 Stewart Ave., New Hyde Park, NY 11040. Rome (Italy) 1977. Subspecialty, nephrology. Board eligible. Partnership, solo, group. Available July 1983.

Young J. Ko, M.D., 2927 Dorchester St., Apt. 206, Troy, MI 48084. Chonnam (Korea) 1973. Subspecialty, pulmonary medicine. Board certified (IM); board eligible (PM). Solo, group, partnership. Available July 1983.

Frank Lopez, M.D., 60 Overlook Rd., Summit, NJ 07901. Einstein 1980. Board eligible. Group or partnership. Available.

Louis D. May, M.D., 2122 Kensington Ave., Salt Lake City, UT 84108. Miami 1978. Subspecialty, gastroenterology. Board certified. Group or partnership. Available June 1983.

Leonard Luterman, M.D., 5740 Cavendish Blvd., Apt. 1308, Montreal, Quebec, Canada H4W 2T8. McGill 1977. Subspecialty, gastroenterology. Board eligible. Any type practice. Available July 1983.

M. Zaslow, M.D., 24 Westgate Road, Chestnut Hill, MA 02167. Harvard 1977. Subspecialty, pulmonary medicine. Board certified (IM); board eligible (pulmonary medicine). Any type practice. Available.

David George, M.D., 76 St. Paul Street, Apt. 6, Brookline, MA 02146. Harvard 1978. Subspecialty, rheumatology. Board certified. Group. Available July 1983.

Arthur C. Tutela, M.D., 132 Midland Place, Newark, NJ 07106. Bologna (Italy) 1974. Also, general medicine. Group, partnership, clinic, institution. Available.

Andrew Stolzar, M.D., 3 Petunia Drive, Apt. 2-C, North Brunswick, NJ 08902. Graz (Austria) 1979. Board eligible. Group or partnership. Available July 1983.

Richard M. Moccia, M.D., 10 Loden Lane, Rochester, NY 14620. Dartmouth 1977. Also, gastroenterology. Board certified (IM); board eligible (gastroenterology). Solo, group, partnership, hospital-based practice combining IM and consultative GI. Available June 1983.

Dennis Parenti, M.D., 131-F Marina Drive, Edison, NJ 08817. Washington University 1978. Subspecialty, rheumatology. Board certified (IM); board eligible (rheumatology). Partnership or group. Available July 1983.

NEPHROLOGY—Laurence N. Sechter, M.D., 1870 Stewart Ave., New Hyde Park, NY 11040. Rome (Italy) 1977. Also, general internal medicine. Board eligible. Partnership, solo, group. Available July 1983.

Carl S. Goldstein, M.D., 860 Gates Pavilion, 3400 Spruce St., Philadelphia, PA 19104. Washington University 1978. Also, general internal medicine. Board certified (IM). Group or partnership. Available July 1983.

OBSTETRICS/GYNECOLOGY—Richard Malafy, M.D., 8716 East Spanish Barb. Trail, Scottsdale, AZ 85258. UMDNJ 1971. Board eligible. Any type practice. Available.

Andrew R. Herzog, M.D., 310 East 23rd St., New York, NY 10010. New York Medical 1979. Board eligible. Group or partnership. Available July 1983.

Francine A. Guzman, M.D., 132-17 58th Road, Flushing, NY 11355. New York Medical 1979. Board eligible. Group or partnership. Available June 1983.

Ho Young Kim, M.D., 1945 Corlies Avenue, Neptune, NJ 07753. Chonnam (Korea) 1972. Board eligible. Solo, group, partnership. Available July 1983.

ONCOLOGY/HEMATOLOGY—Shailesh J. Shah, M.D., 430 E. 67th St., Apt. 5-C, New York, NY 10021. Baroda (India) 1974. Special interest in pediatrics. Group, partnership, institutional. Available July 1983.

OPHTHALMOLOGY—Michael Hostovsky, M.D., 4100 West 36th St., Minneapolis, MN 55416. Hadassah (Israel) 1972. Also, neuro-ophthalmology. Board eligible. Single or multispecialty group. Available.

Jasvinder Singh, M.D., 500 Central Ave., Apt. 702, Union City, NJ 07087. Lady Hardinge (India) 1970. Board eligible. Partnership, group, HMO. Available.

OTOLARYNGOLOGY—Richard Schiffman, M.D., 2717 East 28th St., Brooklyn, NY 11235. Tufts 1977. Board eligible. Partnership or group. Available.

Kwang H. Choi, M.D., 8704 Pellington Place, Apt. 3, Richmond, VA 23229. Seoul (Korea) 1976. Board eligible. Partnership or associates. Available July 1983.

Bruce Grossman, M.D., 215 East Chicago Ave., Apt. 1101, Chicago, IL 60611. Illinois 1978. Board eligible. Group or partnership. Available July 1983.

PATHOLOGY—Siamak Shokri-Tabibzadeh, M.D., Montefiore Hospital and Medical Center, 111 E. 210th St., Bronx, NY 10467. Tehran (Iran) 1977. Academic institution. Available February 1983.

Marvin N. Solomon, M.D., 3 Sutliff Ave., Vineland, NJ 08360. Berne (Switzerland) 1937. Special interest in anatomic and forensic. Board certified (PA); board eligible (forensic). Hospital staff, locum tenens. Available.

Pushpa Gupta, M.D., 100-C Thorndale Dr., Dayton, OH 45429. Dr. S.N. Medical College (India) 1971. Any type practice. Available.

PEDIATRICS—Shailesh J. Shah, M.D., 430 E. 67th St., Apt. 5-C, New York, NY 10021. Baroda (India) 1974. Board eligible. Special interest in pediatric hematology/oncology. Group, partnership, institutional. Available July 1983.

Renuka D. Desai, M.D., 1258 Liberty Bell Dr., Cherry Hill, NJ 08003. GS Medical College (India) 1973. Board certified. Group or partnership. Available.

Ann M. Hawryluk, M.D., 1804 Windsor Ridge Dr., Westborough, MA 01581. Harvard 1980. Board eligible. Group, partnership, HMO, solo. Available July 1983.

Edgar C. Orate, M.D., 1945 Corlies Ave., Neptune, NJ 07753. University of the East (Philippines) 1978. Board eligible. Group, partnership, solo. Available July 1983.

PSYCHIATRY—Paul L. Maitheny, M.D., 99 Pawnee Rd., Lakewood, NJ 08701. University of Graz (Austria) 1951. Board eligible. Available.

PULMONARY DISEASES—Young J. Ko, M.D., 2927 Dorchester St., Apt. 206, Troy, MI 48084. Chonnam (Korea) 1973. Also, general internal medicine. Board certified (IM); board eligible (PM). Solo, group, partnership. Available July 1983.

M. Zaslow, M.D., 24 Westgate Road, Chestnut Hill, MA 02167. Harvard 1977. Also, general internal medicine. Board certified (IM); board eligible. Any type practice. Available.

RADIOLOGY—Stephen Phillip Laufgraben, M.D., 19 Poplar Ave., Wheeling, WV 26003. University of Arkansas 1973. Board certified. Single-specialty group, hospital based, private. Available.

M. T. Centanni, M.D., Box 222, Bloomfield, NJ 07003. Bologna (Italy) 1970. Board certified. Group or hospital (full time). Available.

RHEUMATOLOGY—David George, M.D., 76 St. Paul St., Apt. 6, Brookline, MA 02146. Harvard 1978. Also, general internal medicine. Board certified (IM). Group. Available July 1983.

SURGERY, GENERAL—Mohammad Amawi, M.D., 1904 Barham St., Dodge City, KS 67801. Damascus (Syria) 1971. Board certified. Group, partnership, multi-specialty group. Available.

Larry E. Shindelman, M.D., 201 W. 89th St., New York, NY 10024. SUNY-Downstate 1977. Also, vascular surgery. Board eligible. Group or partnership. Available July 1983.

James P. Gadzik, M.D., 414 Country Lane, Narberth, PA 19072. Pennsylvania 1976. Group, partnership, general surgery (with vascular and thoracic). Available July 1983.

SURGERY, ORTHOPEDIC—Mark S. Berkowitz, M.D., 1045-55th St., Brooklyn, NY 11219. New York Medical 1978. Board eligible. Group or partnership. Available July 1983.

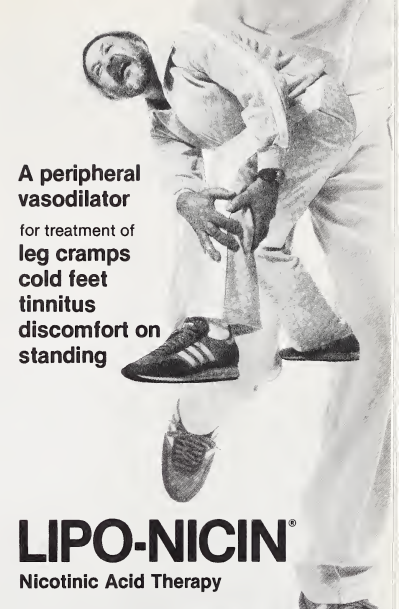
Shearwood J. McClelland, M.D., 380 E. Town St., Columbus, OH 43215. Columbia 1974. Board certified. Partnership or group. Available.

SURGERY, THORACIC—John P. Hubert, Jr., M.D., 33 Viking Village, N.W., Rochester, MN 55901. Minnesota 1975. Board certified. Private practice, single specialty in small group. Available July 1983.

SURGERY, VASCULAR—Larry E. Shindelman, M.D., 201 W. 89th St., New York, NY 10024. SUNY-Downstate 1977. Also, general surgery. Board eligible. Group or partnership. Available.

John P. Hubert, Jr., M.D., 33 Viking Village, N.W., Rochester, MN 55901. Minnesota 1975. Board certified. Private practice, single specialty in small group. Available July 1983.

UROLOGY—Howard L. Frey, M.D., 10982 Roebling Ave., Apt. 425, Los Angeles, CA 90024. Johns Hopkins 1977. Subspecialty, infertility and microsurgery. Board eligible. Group, partnership, solo. Available July 1983.



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discomfort on standing

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Nicotinic Acid Therapy

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Nicotinic Acid .....300 mg.
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Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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MEDICAL PHILATELY

Modern Medicine

JOSEPH H. KLER, M.D., New Brunswick

Constantin von Economo, M.D., (1876-1931) was born in Trieste, a scion of wealthy landowners of Greek descent. He became fluent in five languages. After receiving his medical degree in 1901 from the University of Vienna, Dr. von Economo spent several years studying neuropsychiatry in France and Germany. From 1906 throughout his professional life, Dr. von Economo worked in Vienna in the field of neuropsychiatry.

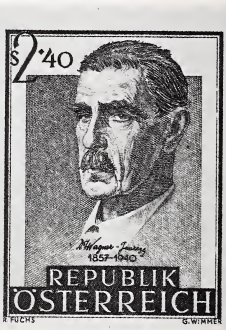


von Economo
Austria, 1976

In 1917, he acquired worldwide fame by being the first to recognize and describe a hitherto unknown disease entity which in subsequent years became a pandemic disorder and then disappeared. It was epidemic encephalitis, which Dr. von Economo called "lethargic encephalitis." A brilliant researcher, excellent lecturer, and prolific writer, he produced seven major monographs and 51 papers, and wrote an encyclopedic book on the cerebral cortex.

Julius Wagner-Jauregg, M.D., (1857-1940) was born in Wels, Austria, and received his medical degree from the University of Vienna in 1881. He joined the medical staff of the University of Graz and became Professor of Neurology and Psychiatry. He discovered that endemic goiter and cretinism could be prevented by adding iodine to salt.

In 1887, Dr. Wagner-Jauregg postulated the general theory of the effect of febrile disease on psychoses and, in 1890, experimented with the use of tuberculin towards this goal.



Wagner-Jauregg
Austria, 1957

In 1917, Dr. Wagner-Jauregg instituted the therapeutic use of malaria in the treatment of general paresis and dementia paralytica of cerebrospinal syphilis, for which he was honored with the Nobel Prize in Medicine and Physiology in 1927. (The introduction of antibiotics and steroids has replaced malaria and cabinet fever therapy.)

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, The Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Feb.

19 **Clinical Anesthesia 1983**
8 a.m.-4 p.m.—NJ Medical School, Newark
(UMDNJ and AMNJ)

Mar.

19 **Postgraduate Anesthesia Seminar**
20 Hyatt House, Cherry Hill
(NJ State Society of Anesthesiologists and AMNJ)

CARDIOLOGY

Feb.

2 **Cardiac Rehabilitation**
1 p.m.—Christ Hospital, Jersey City
(AMNJ)

MEDICINE

Feb.

1 **Adrenal Disease**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

2 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

2 **Burns: Current Treatment**
1 p.m.—Christ Hospital
(AMNJ)

2 **Endocrine Conferences**
3:30-5 p.m.—Rotates between Newark Beth Israel Medical Center University Hospital, United Hospital Medical Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

2 **Dinner Meeting**
6-9:30 p.m.—Holiday Inn, Newark Airport
(Endocrinology Section of AMNJ)

2 **Topic to be announced**
6:30 p.m.—The Manor, West Orange
(Urology Section, AMNJ)

2 **Internal Medicine Review Course**
9 3-6 p.m.—Clara Maass Medical Center, Belleville
(Clara Maass Medical Center and AMNJ)

2 **Endocrine Conferences**
9 9:30-5 p.m.—Rotates between
16 Newark Beth Israel Medical Center,
23 University Hospital, United Hospital Medical Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

3 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section of AMNJ)

4 **Medical Grand Rounds**
11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section of AMNJ)

4 **Renal Conferences in Nephrology**
4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section of AMNJ)

5 **Gram-negative Bacteremia and Septic Shock**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

9 **Diabetic Nephropathy**
16 **Sudden Death: Causes, Prevention**
23 **Update: Viral Hepatitis**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

9 **Hormone Receptors**
23 **Pancreatic Islet Cell Tumors**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

10 **Antiarrhythmic Therapy**
2 p.m.—John E. Runnells Hospital of Union County, Berkeley Heights
(AMNJ)

11 **Oral Analgesics**
12:15-1:15 p.m.—J.F. Kennedy Memorial Hospital, Stratford
(UMDNJ, J.F. Kennedy Memorial Hospital, and AMNJ)

15 **Gastrointestinal Bleeding**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

15 **CAPD-Recent Advances**
4-5 p.m.—Academic Health Science Center Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

16 **Diabetes**
10:30-11:30 a.m.—South Bergen Hospital, Hasbrouck Heights
(AMNJ)

16 **Dermatological Conferences**
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

16 **Regulation of Postassium-renal and Extrarenal Mechanisms**
7:30-8:30 p.m.—Ramada Inn, Clark
(Nephrology Society and AMNJ)

25 **Nonsurgical Management of Benign and Malignant Esophageal Strictures**
8-10 p.m.—Englewood Club, 115 E. Palisade Ave., Englewood
(Englewood Surgical Society and AMNJ)

29 **Prophylactic Antibiotic Therapy**
9:30-11:30 a.m.—Riverside Hospital, Boonton
(Riverside, St. Clare's, and Dover General Hospitals, and AMNJ)

Mar.

2 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

2 **Dinner Meeting**
6-9:30 p.m.—Holiday Inn, Newark Airport
(Endocrinology Section of AMNJ)

2 **New Infectious Disease Syndromes**
9 **Diagnosis and Management of Acute Renal Failure**
16 **Magnesium and Phosphate Depletion**
23 **Pathophysiology of the Chronic Obstructive Lung Diseases**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

2 **Internal Medicine Review Course**
9 3-6 p.m.—Clara Maass Medical Center,
16 Belleville
23 *(Clara Maass Medical Center and*
30 *AMNJ)*

2 **Endocrine Conferences**
9 3:30-5 p.m.—Rotates between Newark
16 Beth Israel Medical Center, University
23 Hospital, United Hospital Medical
30 Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

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March 5, 1983

MARRIOTT MOTOR HOTEL

City Line Ave. at Monument Rd., Philadelphia, Pa.

8:30- 9:00	REGISTRATION AND COFFEE	
9:00-10:30	INFLAMMATORY BOWEL DISEASE—MODERATOR: JAMES L.A. ROTH, M.D.	
	H.R. Clearfield—Nutrition	I.S.E. Gibbons—Ca Surveilance
	J.J. Deren—"Gay Bowel"	F. Goldstein—Rx
10:30-10:45	COFFEE	
10:45-12:15	NEW DIAGNOSTIC & THERAPEUTIC MODALITIES— MODERATOR: WILLIAM H. LIPSHUTZ, M.D.	
	N.N. Cohen—Endosc. Gastrostomy	G.M. Levine—Breath Tests
	A.J. DiMarino—Manometry for DDX Chest Pain	W.N. Mahood—Peritoneoscopy
12:15- 1:30	LUNCHEON	
1:30- 3:00	HEPATITIS—MODERATOR: MARTIN BLACK, M.D.	
	E. Abrutyn—B Vaccine	B.W. Trotman—Nat. Hx of Hep. B
	G. Benson—Rx Chr. Hepatitis	J. Watkins—Vaccine Strategy
3:00- 3:15	COFFEE AND COKE	
3:15- 4:45	NEWER ULCER THERAPY—MODERATOR: ROBERT S. FISHER, M.D.	
	S.P. Bralow—Antacids & Antichol.	S. Peikin—Prostagland.
	F.P. Brooks—Sucrulf. Surface Agts.	W. Rubin—H_2 Blockers

American Academy of Family Physicians	6 hours
Pennsylvania Academy of Family Physicians	6 hours
AMA Physicians' Recognition Award—Category I	6 hours
American College of General Practitioners in Osteopathic Medicine and Surgery—Class II	6 hours

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3 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section of AMNJ)

3 **Congenital Adrenal Hyperplasia**
9 a.m.—Freehold Area Hospital
(AMNJ)

4 **Medical Grand Rounds**
11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section of AMNJ)

4 **Renal Conferences in Nephrology**
18 4-5 p.m.—University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section of AMNJ)

8 **Diabetes**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

9 **Sexually Transmitted Diseases**
23 **Biliary Stone Saga: Endoscopic Removal of Gallstones**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

11 **Newer Therapeutic Agents**
12:15-1:15 p.m.—J.F. Kennedy Memorial Hospital, Stratford
(UMDNJ-School of Osteopathic Medicine, J.F. Kennedy Memorial Hospital, and AMNJ)

11 **Diagnosis of Viral Illness in a Community Hospital**
8:15-9:45 a.m.—Overlook Hospital, Summit
(Overlook Hospital, Columbia University College of Physicians and Surgeons, and AMNJ)

12 **Medicolegal Symposium on Emergency Care**
9:30 a.m.-4:15 p.m.—Hyatt Hotel, New Brunswick
(American College of Emergency Physicians, NJ Affiliate American Heart Association, and AMNJ)

15 **Current Burn Therapy**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

15 **Drug-Induced Acute Interstitial Nephritis**
4-5 p.m.—Academic Health Science Center Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

16 **Joint Conference**
9 a.m.-3:45 p.m.—Coachman Inn, Cranford
(NJ Thoracic Society, NJ Chapter, American College of Chest Physicians, and AMNJ)

16 **Rutgers Dermatological Conferences**
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

17 **Clinical Syndromes Related to Gastrointestinal Gas**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

18 **CDS Prescribing Practices**
1:15-2:15 p.m.—Marlboro Psychiatric Hospital
(AMNJ)

21 **Nephritis**
12 noon-1 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)

22 **American Medical Society of Andrology**
23 National Meeting
24 Independence Holiday Inn, 4th and Arch
25 Sts., Phila.
(Cooper Medical Center and AMNJ)

23 **Morbid Obesity**
9:30-11:30 a.m.—Riverside Hospital, Boonton
(Riverside, St. Clare's, Dover General Hospital, and AMNJ)

23 **Renal Adaption to Low Potassium Intake**
7:30-8:30 p.m.—Ramada Inn, Clark
(Nephrology Society and AMNJ)

24 **Clinical Pharmacology of the Antibiotics**
31 **Chronic Obstructive Lung Disease**
11 a.m.-12:30 p.m.—St. Joseph's Hospital & Medical Center, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

24- **Thirty-first Annual Convention**
27 Golden Nugget Hotel, Atlantic City
(NJ Academy of Family Physicians)

30 **Symposium on Drug Allergy**
9-11:30 a.m.—Muhlenberg Hospital, Plainfield
(NJ Allergy Society and AMNJ)

NEUROLOGY/PSYCHIATRY

Feb.

2 **Diagnosis and Treatment of Depressive Disorders**

16 **Panic Attacks: Acute Anxiety**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

2 **Child Psychiatry Case Conferences**
9 10 a.m.-12 noon—Trenton Psychiatric
16 Hospital
23 *(Trenton Psychiatric Hospital and AMNJ)*

4 **The Electroencephalogram—Its Indications and Interpretations**
1-2:30 p.m.—Marlboro Psychiatric Hospital
(Marlboro Psychiatric Hospital and AMNJ)

4 **Psychiatric Medicine 1983**
5 8:30-10:30 p.m.—Grossinger's
(Valley Hospital and AMNJ)

7 **Burnout in a Gay Lady**
8:15-10:30 p.m.—543 Park St., Upper Montclair
(Essex Psychiatric Seminar and AMNJ)

7 **Psychiatric Case Conferences**
14 7:30-11:45 a.m.—Trenton Psychiatric
21 Hospital
28 *(Trenton Psychiatric Hospital and AMNJ)*

16 **Neurotransmitters of the Brain**
3-4 p.m.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

19 **Eating Disorders (Obesity and Anorexia)**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

Mar.

2 **Pharmacology of Antipsychotic Agents**
23 3-4 p.m.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

2 **Child Psychiatry Case Conference**
9 10 a.m.-12 noon—Trenton Psychiatric
16 Hospital
23 *(Trenton Psychiatric Hospital and AMNJ)*

30 **Pathologic Love**
8:15-10:30 p.m.—39 Crescent Ave., Passaic
(Essex Psychiatric Seminar and AMNJ)

7 **Psychiatry Case Conference**
14 7:30-11:30 a.m.—Trenton Psychiatric
21 Hospital
28 *(Trenton Psychiatric Hospital and AMNJ)*

9 **Immunoregulation in Multiple Sclerosis**
6-8 p.m.—The Manor, West Orange
(Neurology Section, AMNJ)

10 **Multidisciplinary Approach to Cerebrovascular Insufficiency**
8-9 p.m.—Burlington County Memorial Hospital, Mt. Holly
(Burlington County Medical Society and AMNJ)

11 **Joint Meeting with NJ Psychoanalytic Society**
8:30-10:30 p.m.—Ramada Inn, Clark
(New Jersey Psychiatric Association and AMNJ)

11 **Psychiatric Lecture Series**
18 1:30-5 p.m.—Trenton Psychiatric
25 Hospital
(Trenton Psychiatric Hospital and AMNJ)

22 **Laboratory Interpretations**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

OBSTETRICS/GYNECOLOGY

Mar.

11 **Semmelweis-Waters Obstetrical/Gynecological Conference**
12 8 a.m.-5:50 p.m.—Resorts International
13 Atlantic City
(UMDNJ and AMNJ)

PATHOLOGY

Feb.

3 **Antigen and Human Tumors**
10 **Hormone Receptors and Action**
17 **Growth Factors**
24 **Hormones and Cancer**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

Mar.

3 **Crown Gall**
10 **Insect Hormones**
17 **Cell Models**
24 **Teratocarcinoma**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

PEDIATRICS

Feb.

2 **Neonatal Problems**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

11 **Evaluation of Patient with Suspected Metabolic Diseases**
8:15-9:45 a.m.—Overlook Hospital, Summit
(Overlook Hospital, Columbia University

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CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

WEDNESDAY, FEBRUARY 2, 1983

20 minute lectures—Questions and Answers (10 minutes)
MODERATOR: BERNARD L. SEGAL, M.D.

UNSTABLE ANGINA PECTORIS: NITRATES, BETA-BLOCKERS, CALCIUM-BLOCKERS—FOR WHOM AND WHY?
Bernard L. Segal, M.D.

PREDICTORS OF SUDDEN DEATH IN PATIENTS WITH CORONARY HEART DISEASE
Joel Morganroth, M.D.

THE TREATMENT OF ARRHYTHMIAS WITH CALCIUM-BLOCKING AGENTS—CASE PRESENTATION
Scott R. Spielman, M.D.

THE VALUE OF ECHOCARDIOGRAPHY IN PATIENTS WITH CORONARY HEART DISEASE
Morris N. Kotler, M.D.

CASE PRESENTATION/DISCUSSION
Daniel Mason, M.D.

3:00 PM—2nd floor New College Building, Hahnemann University
• NO REGISTRATION FEE • NO ADVANCE REGISTRATION REQUIRED •
• CME CATEGORY I CREDITS CERTIFIED •
WINE & CHEESE SERVED FOLLOWING CONFERENCE

College of Physicians and Surgeons, and AMNJ)

Mar.

19 Sports-related Injuries in Children and Adolescents
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

RADIOLOGY

Feb.

3 Columbia Affiliate Radiology Lecture
5:30-6:30 p.m.—Morristown Memorial Hospital
(Morristown Memorial Hospital, Overlook Hospital, and AMNJ)

10 Interesting Case Panel
7:30-9:30 p.m.—St. Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine and AMNJ)

Mar.

3 Columbia Affiliate Radiology Lecture Series
5:30-6:30 p.m.—Overlook Hospital
(Morristown Memorial Hospital, Overlook Hospital, and AMNJ)

16 Dinner Meeting
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

19 Computers in Radiology
8 a.m.—Sheraton Inn, Newark Airport
(NJ Institute of Ultrasound in Medicine, Radiological Society of NJ, and AMNJ)

SURGERY

Mar.

2 Breast Cancer
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

2 In and Out Surgery
11:30 a.m.—Columbia Hospital, Newark
(AMNJ)

9 Alternative to Standard Ileostomies
9:30-11:30 a.m.—Riverside Hospital, Boonton
(Riverside, St. Clare's, Dover General Hospitals, and AMNJ)

9 Statewide Tumor Board Conference
5:30 p.m.—Academy of Medicine of NJ, Lawrenceville
(Oncology Society of NJ)

16 High-risk Surgery
11:30 a.m.-12:30 p.m.—Rahway Hospital
(AMNJ)

16 Lumpectomy and Radiation: Treatment of Early Breast Cancer
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

22 Management of Breast Cancer
6:30-10 p.m.—Coachman Inn, Cranford
(NJ Blood Club and AMNJ)

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastics, and Vascular Surgery)

Feb.

17 Appropriate Uses of Analgesic Agents in Musculoskeletal Injuries
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

Mar.

5 The Back Is Back
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

16 Dinner Meeting
6:30-9:30 p.m.—The Manor, West Orange
(NJ Society of Colon and Rectal Surgeons and AMNJ)

22 Advances in Head and Neck Surgery
8-10 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

30 Head and Neck Cancer
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

MISCELLANEOUS

Feb.

3 Computer in Medicine
9 a.m.—Freehold Area Hospital
(AMNJ)

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

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It is normal human behavior to ignore problems that appear insoluble. Unfortunately, the psychopathy of substance abuse and addiction always gets worse while it is ignored.

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Help us to help our impaired colleagues.

OBITUARIES

Dr. Ralph R. Autorino

Word has been received of the death of Ralph Robert Autorino, M.D., a member of our Essex County component, on August 15, 1982. Born in 1916, Dr. Autorino received his medical degree from New York University School of Medicine in 1942. A family practitioner, Dr. Autorino was affiliated with The Mountainside Hospital, Montclair.

Dr. Arthur J. D'Alessandro

An emeritus member of our Essex County component, Arthur Joseph D'Alessandro, M.D., died on September 27, 1982. Born in 1911, Dr. D'Alessandro was graduated from Columbia University College of Physicians and Surgeons, New York, in 1935. During his career, Dr. D'Alessandro was affiliated with St. James Hospital, Newark. Dr. D'Alessandro was a member of the American Medical Association and of The Academy of Medicine of New Jersey and a Fellow of the American College of Surgeons. Dr. D'Alessandro retired from practice in 1975.

Dr. John K. de Vries

At the grand age of 82, John Kremer de Vries, M.D., died on October 26, 1982. Dr. de Vries earned a medical degree at Wayne State University College of Medicine, Michigan, in 1926. During his lengthy career, Dr. de Vries was a urologist affiliated with Overlook Hospital, Summit, and Saint Barnabas Medical Center, Livingston. Dr. de Vries was an emeritus member of our Essex county component and a member of the American Medical Association.

Dr. Ferdinand C. Dinge

At the grand age of 84, Ferdinand Charles Dinge, M.D., died on September 18, 1982. A graduate of Jefferson Medical College, Philadelphia, in 1927, Dr. Dinge was affiliated with Saint Barnabas Medical Center, Livingston, and Memorial Hospital, Orange. Dr. Dinge was an emeritus member of our Essex County component, a member of the American Medical Association, and a Fellow of the American College of Physicians.

Dr. Leon Friedman

Leon Friedman, M.D., died on October 4, 1982. Born in 1915, Dr. Friedman earned a medical degree at the University of Pennsylvania School of Medicine, Philadelphia, in 1938. Dr. Friedman was a general surgeon affiliated with Warren Hospital, Phillipsburg. He was a member of our Warren County component and of the American Medical Association, a Diplomate of the American Board of Surgery, and a Fellow of the American College of Surgeons and of the International College of Surgeons.

Dr. Angelo D. Guglielmelli

Angelo Domenic Guglielmelli, M.D., died on September 9, 1982. Born in 1906, Dr. Guglielmelli earned a medical degree at Hahnemann Medical College, Philadelphia. He was chief of surgery at the former Trenton General Hospital and he was instrumental in establishing Hamilton Hospital. In 1980, Dr. Guglielmelli received MSNJ's Golden Merit Award for 50 years of distinguished service as a physician. Dr. Guglielmelli was a member of our Mercer County component and of the American Medical Association and was a Fellow of the International College of Surgeons.

Dr. Frederick A. Hansey

At the age of 80, Frederick Aloysius Hansey, M.D., died on October 15, 1982. He received his medical degree from Georgetown University in 1926. A retired member of our Essex County component, Dr. Hansey was a general practitioner affiliated with St. Mary's Hospital, Orange. He was the Medical Inspector for West Orange schools. Dr. Hansey was a member of the American Medical Association.

Dr. John A. Ianacone

John Anthony Ianacone, M.D., a member of our Passaic County component, died on October 22, 1982, as a result of an automobile accident. Born in 1908, Dr. Ianacone was graduated from Georgetown University School of Medicine, Washington, DC, in 1932. During his lengthy career, Dr. Ianacone was affiliated with Fair Lawn Memorial Hospital, Barnert Memorial Hospital, Paterson, Greater Paterson General Hospital, and Valley Hospital, Ridgewood. He was a member of the American Medical Association and a Fellow of the International College of Surgeons. Dr. Ianacone was an editor of the Passaic County Medical Society Monthly Bulletin.

Dr. Benoit C. Isaac

Benoit Conrad Isaac, M.D., a retired member of our Essex County component, died on November 3, 1982. Born in 1908, Dr. Isaac was graduated from Howard University Medical School, Washington, DC, in 1936. A general practitioner, Dr. Isaac was affiliated with General Hospital, East Orange, and Memorial Hospital, Orange. He was the physician for the Orange public school system until his retirement in 1977. He was a member of the American Medical Association.

Dr. Frederick J. Levy

At the untimely age of 39, Frederick Jerome Levy, M.D., died on September 27, 1982. A graduate of UMDNJ in 1973, Dr. Levy interned at University Hospital, Newark. Dr. Levy established a practice in Elizabeth in 1978, specializing in infectious diseases. Dr. Levy was a member of our Union County component and of the American Medical Association.

Dr. Anthony F. Magolda

Anthony Francis Magolda, M.D., died on October 18, 1982. Born in 1908, Dr. Magolda earned a medical degree at Hahnemann College of Medicine, Philadelphia, in 1936. He was a family practitioner for over 40 years in Vineland. During his career he was affiliated with Newcomb Hospital, Vineland. Dr. Magolda was a member of our Cumberland County component and of the American Medical Association.

Dr. John J. Mosig

An emeritus member of our Monmouth County component, John J. Mosig, M.D., died on October 15, 1982. Born in 1913, Dr. Mosig was graduated from Hahnemann Medical College in 1942. He was a surgeon and general practitioner in Paterson for 30 years before retiring in 1980. Dr. Mosig was affiliated with Jersey Shore Medical Center, Neptune. He was a member of the American Medical Association and a Fellow of the International College of Surgeons.

Dr. Joseph Nussbaum

Word has been received of the death of Joseph Nussbaum, M.D., on June 2, 1981. Born in 1900, Dr. Nussbaum earned a medical degree at the University of Vienna in 1928. During his career Dr. Nussbaum was affiliated with Saint Elizabeth Hospital and Alexian Brothers Hospital, both in Elizabeth, and Newark Beth Israel Medical Center. He was an emeritus member of our Union County component and a member of the American Medical Association.

Dr. Bertha D. Rados

At the grand age of 87, Bertha Drapkin Rados, M.D., died on October 3, 1982. Born in 1895 in Russia, Dr. Rados received a medical degree from the University of Zurich, Switzerland, in 1919. Dr. Rados was Chief, Eye Service, at Newark Beth Israel Medical Center. She retired from practice in 1980. Dr. Rados was a member of our Essex County component and of the American Medical Association, and a Diplomate of the American Board of Ophthalmology.

Dr. Anton P. Randazzo

On October 14, 1982, Anton Philip Randazzo, M.D., a member of our Passaic County component, died. Born in 1906, Dr. Randazzo was graduated from McGill University College of Medicine, Canada, in 1932. He was Attending Surgeon at Passaic General Hospital. Dr. Randazzo received MSNJ's Golden Merit Award for 50 years of distinguished service to the medical community. He was a member of the American Medical Association and a Fellow of the International College of Surgeons.

Dr. Harvey J. Shwed

At the untimely age of 48, Harvey Jack Shwed, M.D., died on November 3, 1982. Dr. Shwed was graduated from Albany Medical College, New York, in 1968. He was Codirector, Psychiatry Institute, Saint Michael's Medical Center, Newark, since 1971. Also, he was Chief of Residency Training, Department of Psychiatry and Mental Health Science, University Hospital, Newark. Dr. Shwed was a Diplomate of the American Board of Psychiatry and Neurology, and he was a member of our Essex County component, of the American Medical Association, and of the American Psychiatric Association. Dr. Shwed was affiliated with Newark Beth Israel Medical Center and St. James Hospital, Newark.

Dr. Franklin Simon

At the age of 63, Franklin Simon, M.D., a retired member of our Essex County component, died on November 3, 1982. Dr. Simon earned a medical degree at New York University Medical School in 1943. Dr. Simon practiced internal medicine in Millburn for 35 years before retiring. He was affiliated with Saint Barnabas Medical Center, Livingston, and Newark Beth Israel Medical Center. Dr. Simon was a member of the American Medical Association, and a Fellow of the American College of Angiology and of the American Geriatric Society.

BOOK REVIEWS

Clinical Pediatric and Adolescent Endocrinology

Solomon A. Kaplan, M.D., (ed). Philadephia, PA, W.B. Saunders Company, 1982. Pp. 416. ($39.50)

Thirty-two years ago, Lawson Wilkins, Associate Professor of Pediatrics at the Johns Hopkins University, Harriet Lane Home, and one of the founding fathers of pediatric endocrinology, wrote the classic book, *The Diagnosis and Treatment of Endocrine Disorders.* Until now I considered it the outstanding book on the subject.

After reviewing Solomon A. Kaplan's book I feel that *Clinical Pediatric and Adolescent Endocrinology* is a qualified successor. Kaplan is aided by 18 contributors many of whom are world famous in pediatric endocrinology. The preface states that the primary goal of the authors and editor is to provide a practical reference source for knowledge regarding endocrine disorders affecting infants, children, and adolescents. They do it and do it well.

The chapters are well written and comprehensive. The approaches to various problems are practical and the information is up to date.

This book should meet the needs of medical students and practicing pediatricians. In fact, I would recommend it to any physician dealing with children.

Albert P. Rosen, M.D.

Correlative Neuroanatomy and Functional Neurology

J.C. Chusid, M.D. Los Altos, CA, Lange Medical Publications, 1982. Pp. 496. ($15)

Eighteen editions since 1938 attest to the excellence and wide reception of this work. Although the author states in the preface that *Correlative Neuroanatomy and Functional Neurology* is intended for the beginner in clinical neurology, it is a remarkably complete review for all practitioners, general or specialized. The price could not be better. The format is readable, the illustrations supplement the terse text, and the photographs are appropriate and of good quality. The latter half of the book is devoted to clinical aspects of neurology and is equally as appropriate.

Delay in publication of a book of this sort results in omission of the newest techniques to come on the scene. There is no mention of nuclear magnetic resonance and the chapter on angiography does not refer to the less dangerous digital vascular imaging. While a quarter of a page is allotted to visual evoked potentials, no mention is made of the currently increasing usage of evoked potentials to diagnose spinal cord and brain stem lesions. Nor is there any description of CAT scans of the spinal column used as a noninvasive technique for the diagnosis of discs, tumors, and spinal stenosis.

In the same vein, it might be wise to eliminate most of the 1960 and earlier textbook references since they are rarely available in hospital and medical school libraries today. Perhaps the inclusion of one or two representative articles in current journals would make this delightful softcover an even more important addition to the practitioner's resources. Pleasure and education will result in perusing this work.

Henry R. Liss, M.D.

Critical Care for Surgical Patients

John Beal, M.D., (ed). New York, NY, Macmillan Publishing Co., 1982. Pp. 606. ($48)

During the past three decades, the care of the critically ill patient has become better organized and more efficient and has involved an increasing number of health care professionals. In 1957, the postoperative recovery room often was the only special care unit in many hospitals. In the ensuing years, intensive care units appeared with increasing frequency. The concept of special units proved sound and expanded to provide care for a variety of patients, e.g. coronary care, pulmonary care, neurosurgical intensive care, and trauma units. It is only fitting for the pioneer, J.M. Beal, M.D., to edit a compendium of valuable information.

In this multidisciplinary volume, members of the major clinical departments at Northwestern University Medical School and affiliated teaching hospitals in Chicago present the basic principles in the management of the critically ill surgical patient. The contributors represent diverse special areas, including the nursing service, and the departments of respiratory therapy, anesthesia, internal medicine, surgery, urology, ophthalmology, and obstetrics/gynecology.

Critical Care for Surgical Patients consists of 34 authoritative chapters. Unit I is concerned with respiratory problems. Unit II deals with cardiovascular crises. Unit III is devoted to general surgical care. Problems in the surgical specialties are discussed in Unit IV. Unit V covers pediatric surgical emergencies. Unit VI encompasses medical problems in surgical patients.

Each chapter is well organized, informative, and documented. One minor distraction to the free flow of reading is the insertion of author and year references in specific subject matter.

This text should be read as well as used for reference by all health professionals who assume responsibility for critically ill patients.

Stanley S. Fieber, M.D.

Current Gastroenterology, Volume 1

Gary L. Gitnick, M.D., (ed). New York, NY, John Wiley & Sons, Inc., 1982. ($45)

This is a collection of essays reviewing the current literature on selected topics in gastroenterology. The authors are distinguished in their fields and have done a good job of burrowing out the chaff and writing clearly. The book will interest those in gastroenterology as consultants, GI fellows, and residents rotating through GI.

A generalist may read a chapter in the library to help with a perplexing case, and save time and frustration by avoiding the need to pursue journal references. The book is nicely printed in reasonable size type; the illustrations generally are very good. References are adequate and recent.

This reviewer recommends reading *Current Gastroenterology, Volume 1,* but purchasing only for the interested specialist.

Norman Riegel, M.D.

Intensive Care of the Surgical Patient

Marshall D. Goldin, M.D., (ed). Chicago, IL, Year Book Publishers, Inc., 1982. Pp. 672.

Intensive Care of the Surgical Patient is a useful reference manual for hospital medical libraries and also will be useful in the intensive care unit. It is quite a comprehensive text covering most problems encountered in an intensive care unit.

The contents represent a compilation of procedures and concepts used by many physicians. The material is well handled. The book itself is attractive and printed on fine stock.

The section on radiology will be very useful. The book should be considered a reference volume, but there is considerable yield in reading the entire volume in slow sessions.

I am pleased to recommend the book.

Robert K. Spiro, M.D.

Introductory Physics of Nuclear Medicine 2nd Edition

Ramesh Chandra. Philadelphia, PA, Lea & Febiger, 1982. Pp. 237. Illustrated. ($17.50)

In this second edition, the author provides an overview of the physical basis of nuclear medicine. After a beginning devoted to theory, Chandra directs the reader's attention to the more practical aspects of the field.

The first chapter is a basic review of atomic structure and is geared to the reader who has had no more than an introductory course in chemistry or physics. The book describes the radioactive particles and their decay phenomenon. More practical concepts of the synthesis of the isotope into a radiopharmaceutical follow; the result of the radioisotope's interactions with matter (body), the measurement of radiation patient dose, and the techniques of detection also receive the attention of the author. Detection is subdivided into in vitro methods, in vivo rectilinear scanners, and in vivo gamma camera. After the general description of these detection systems, image quality parameters are reviewed. In his concluding chapters, Chandra discusses positron scanners and other special techniques and instruments as well as the biological risk hazards of radionuclides.

The text is a concise and well-illustrated presentation, highlighting the information necessary for understanding nuclear medicine. Chandra has simplified the more complex mathematical computations.

Neil B. Horner

Learning Disabilities Explained

Stanley S. Lamm, M.D., Martin L. Fisch, Ph.D., Don McDonagh. New York, NY, Doubleday & Company, Inc., 1982. Pp. 247. ($16.95)

Learning Disabilities Explained covers many of the major considerations in the diagnosis and treatment of learning disabilities.

About 15 percent of nursery and grade school children have some kind of learning disability that prevents them from fully achieving their academic and social potential. This book reviews various aspects of this multifaceted problem and presents a multifaceted approach for proper diagnosis and treatment by using input from teachers, psychologists, guidance counselors, speech pathologists, occupational therapists, social workers, and physicians.

Emphasis is placed upon close cooperation between the various professional groups regarding input from each group to be essential.

Clinical examples are presented with specific diagnoses and treatments. Treatment is tailored individually depending upon the disabilities the individual presents. Methods for accurately diagnosing the learning-disabled child from other handicapped children are documented and reveal a greater degree of diagnostic ability now than has been possible in the past.

This text delves deeply enough into various aspects of learning disabilities to be of value as a resource for various professionals interested in the problem. A glossary of frequently used terms is included which makes it easier for interdisciplinary terminology to be utilized. A list of state associations and information sources for children with learning disabilities in all states also is included.

This book is of value for any of the professional community with an interest in learning disabilities.

S. Thomas Westerman, M.D.

1982 Year Book of Plastic and Reconstructive Surgery

Frederick J. McCoy, M.D., (ed). Chicago, IL, Year Book Medical Publishers, Inc., 1982. Pp. 355.

This is another issue of the well-known, popular Year Book series. *Year Book of Plastic and Reconstructive Surgery* was issued in May, 1982, and covers literature reviewed up to July, 1981; thus, the material is presented about one year after originally published —still pretty fresh.

The editors have tried to cover almost all areas of interest to the plastic surgeon. From my point of view there are two good reasons to have this volume in my library: articles that were read, deemed to be of value, mentally noted, then faded into the haze are jogged into freshness and articles are reviewed that appeared in journals which I ordinarily would not see; for example, dentistry, pathology, and ophthalmology. For the general surgeon or other surgical specialist with interest in plastic surgery, this is a valuable review of some of the best of our current literature.

I particularly enjoyed the editorials after each precis. The remarks of these esteemed experts are invaluable. If there is a weakness in this book it is the absence of a title index which I feel would be very useful in looking for material of special interest to the reader.

Edward N. Ludin, M.D.

Outline Guide to Antimicrobial Therapy

John E. McGowan, Jr., M.D. Oradell, NJ, Medical Economics Books, 1982. Pp. 192. ($13.95)

The *Outline Guide to Antimicrobial Therapy* was produced to serve as a quick guide to current available antimicrobial agents for the busy practitioner.

Dr. John E. McGowan, Jr. draws upon his experiences at Harvard and now at Emory Medical School to simplify a complex problem. This book is nothing more than a large print *Physicians' Desk Reference*. It lacks references; it flows poorly; it is oversimplified; and it provides alternatives that generally are not accepted, as noted on page 15, on the section of prophylactic antimicrobials for surgery.

Jay Sanford's *Little Pocket Book* does a better and more complete job. Using the package insert is more reliable than this book. Dr. McGowan confuses the physician by including experimental compounds. The book is a hearty attempt, probably done to educate the author himself, but of poor foundation, and not worth even one dollar.

Leon G. Smith, M.D.

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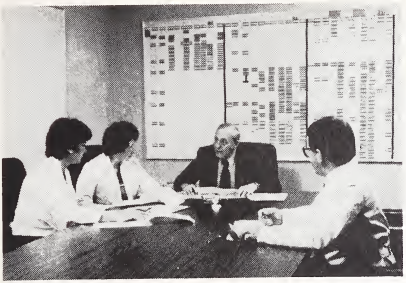
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On The Cover: A pediatric team approach to violent early bereavement was conducted at Newark Beth Israel Medical Center. The integration of medical, nursing, and psychological efforts provides a clear example of the benefit of such teamwork. The case report describes a 41-month-old male who had been shot and had witnessed the murder of his parents. The story begins on page 117. The cover illustration is by Claudia Wainright.

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

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References: **1.** Williams RL, Karacan I: Introduction, chap. 1, in *Sleep Disorders: Diagnosis and Treatment*, edited by Williams RL, Karacan I, Frazier SH. New York, John Wiley & Sons, 1978, p. 2. **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Kales A *et al: JAMA* 241:1692-1695, Apr 20, 1979. **4.** Kales A *et al: J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **6.** Kales A *et al: Clin Pharmacol Ther* 19:576-583, May 1976. **7.** Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med* 5(10):25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. **14.** Kales A, Kales JD: *Pharmacol Physicians* 4(9):1-6, Sep 1970. **15.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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Responsibility in Cases of Child Abuse

Child abuse and neglect are leading causes of physical and emotional damage to children. Last year in New Jersey, 24,707 referrals of child abuse and neglect were reported to the Division of Youth and Family Services. It is estimated that these referrals represent only 20 percent of the total amount of actual child abuse occurring.

Members of the medical profession often have the first contact with abused and neglected children whether in private practice, clinics, or hospitals. Consequently, it is important that physicians be alert and knowledgeable in dealing with suspected cases of physical and/or emotional abuse and neglect of children.

Two New Jersey statutes that detail the role and responsibilities of the physician in handling and reporting cases of suspected child abuse and neglect are: The Child Abuse and Neglect Law (P.L. 1974 c.119, amended by P.L. 1977 c.209) and The Protective Custody Law (P.L. 1975 c.147).

The specifics of the Child Abuse and Neglect Law are:

• Physicians, or any other persons, having reason to suspect that a child has been abused or neglected, are required to report directly to the Division of Youth and Family Services (DYFS) and to provide as much pertinent information as possible, including: name and age of the child; address of parent or guardian; description of the child's condition, type of abuse or neglect to which the child has been subjected, an indication of the seriousness of the situation, and whether the child appears in immediate or imminent danger; and, any other information concerning the circumstances of the abuse or neglect, including any evidence of past abuse or maltreatment. The law also requires that such reports be made only to DYFS, and not to the county prosecutor, as required in the past.

• Any writing, record, or photograph done or taken as a regular course of action by any hospital, agency, or institution is admissible as evidence in any court hearing in cases of suspected abuse or neglect. Also, the law allows DYFS to request of any institution, agency, or private practitioner any past and present records on a particular child—or other children under the care and custody of the same parent or guardian—to aid the agency in its investigation of suspected abuse or neglect. The course of such records has immunity from any liability, civil, or criminal.

• The court also may authorize a physician or hospital to provide emergency medical or surgical treatment if such treatment is necessary to safeguard the child's life or health, and if there is not enough time to conduct a preliminary hearing.

• Whenever DYFS removes a child from his home without parental consent or court order, DYFS is required to arrange for immediate medical examination of the child and shall have legal authority to consent to such examination. The Division's consent to treatment in this instance shall be deemed legal and valid for all purposes. Further, medical reports resulting from such examination must be released to DYFS to be used in aiding in the determination of whether the child has been abused or neglected. Any person or health care facility acting in good faith in the examination of a child or in the release of medical records has immunity from any civil or criminal liability.

• In any case of abuse or neglect, the court may order the examination of a child by a physician, which may include color photographs of visible areas of trauma, as well as radiological examinations. Upon completion of such procedures, the physician is required to submit results to the court ordering the examination.

• Any physician or other person reporting an incident of suspected child abuse or neglect has immunity from any civil or criminal liability. This applies to any testimony given in a judicial proceeding resulting from such action.

The Protective Custody Law, sometimes referred to as the "Hospital Hold" law, empowers any physician or hospital director, or his or her designate, to maintain a child in protective custody without a court order for a period of up to three court days in cases of suspected child abuse or neglect. The specifics of this law are:

• The physician or hospital representative should notify DYFS immediately upon invoking protective custody, and

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Director of Special Projects.

supply the necessary information as outlined in the Child Abuse and Neglect Law.

- The District Office of DYFS then assumes responsibility for conducting an investigation; if custody beyond three days is indicated, the District Office must obtain a court order and locate suitable placement for the child.
- The District Office will inform the parents of the whereabouts of their child and then will forward a copy of the notification to the hospital or institution where the child is being held, telling how notice was served.
- The parents have the right to visit, providing this does not endanger the child. The hospital has the option to determine time and frequency of visits.
- If subsequent investigation indicates further custody is not warranted, the physician or hospital director may terminate custody by contacting DYFS. The Division then may assume further responsibility and provide additional services, as appropriate.
- The person responsible for taking a child into Protective Custody has immunity from civil or criminal liability.

The Division has detailed informational packets on each of these laws; copies can be obtained by writing to the Division of Youth and Family Services, One South Montgomery Street, Trenton, NJ 08625.

To report a suspected case of child abuse and neglect, phone the nearest District Office of Division of Youth and Family Services between 9 A.M. to 5 P.M., Monday through Friday. At all other times use the 24-hour, toll-free emergency hotline: (800) 792-8610.

LAWYERS DEFER VOTE ON ETHICS CODE UNTIL NEXT CONVENTION

At their August convention in San Francisco, members of the American Bar Association, Chicago, debated a proposed revision of the association's code of ethics for almost four hours, finally voting to table the issue until the association meets again in February.

The long-running debate centered on the confidentiality of the relationship between a lawyer and a client. Some members are proposing a new code of professional conduct that would encourage a lawyer to disclose client secrets if a client's actions are likely to result in "substantial injury to the financial interest or property of another." Other members strongly oppose the new guidelines.

"We believe the new wording would allow confidentiality between clients and lawyers to be eroded," says Richard Pruter, Executive Director of the American College of Trial Lawyers, Los Angeles, California, a group that has more than 90 members in the ABA's 387-seat house of delegates. "The basic thrust of the new code is that certain information could be passed on. Our position is that a lawyer cannot represent a client unless he or she knows the whole story, and a client will be reluctant to trust a lawyer with the whole story under the proposed rules."

The new ethics code has been developed over the past five years by an ABA-appointed commission. It is intended to update ABA's Model Code of Professional Responsibility, which is based on 1908 guidelines and officially was adopted in 1969.

The old code outlines three levels of conduct for lawyers: nine general canons of a lawyer's responsibility; ethical considerations that a lawyer should aspire to; and disciplinary rules that guide a lawyer's actions. The new code contains one set of specific rules rather than general statements and could be used legally to discipline lawyers.

As a result of the August debate, commission members have rewritten portions of the new code in preparation for its appearance on the convention agenda in February. Opponents of the new code, such as the American College of Trial Lawyers, also are preparing for the meeting. Mr. Pruter says ACTL's board of regents has appointed a special committee to cite examples of what would happen if the new rules were adopted and to write alternative rules.

If ABA members approve the new professional code, the supreme court and bar association of each state would vote whether to adopt it. *Association Management,* November, 1982.

TOO MANY TESTS?

As the disputes continue over how much diagnostic testing should be done, and whether physicians or insurance companies should make that decision, patients apparently side with physicians. In a recent survey by *Psychology Today* magazine, only 6 percent of respondents said having too many tests bothers them. The pet peeve among 49 percent of those polled is waiting in the office, while 36 percent think they are being charged too much. *Medical Economics,* December, 1982.

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CONTRAINDICATIONS

1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE. In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn. b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levarterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY. Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura. *Central Nervous System:* lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal:* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic:* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory:* bronchospasm. *Hematologic:* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous:* reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings:* Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

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Bad Legislation Proposed: A-2057 and S-1859

What is one of the strangest groups of bedfellows you can imagine? How about the Medical Society of New Jersey, the State Board of Medical Examiners, the New Jersey Hospital Association, and the New Jersey Chiropractic Society? Peek under the sheets and you will find the New Jersey Society of Physical Medicine and Rehabilitation and the New Jersey Orthopaedic Society as well. What could have brought this formidable ensemble together?

Present legislation empowers the Board of Medical Examiners to license physical therapists and to develop and implement the regulations which define the scope of practice of physical therapy. A group of lawmakers in each house of the New Jersey Legislature has cosponsored proposed bills (**A-2057** and **S-1859**) whose impact would include the following:

1. Establish an autonomous Board of Physical Therapy "to license, regulate, and discipline physical therapists and physical therapy assistants."

2. Permit physical therapists to practice independently without supervision by or the need of referral from physicians.

3. Authorize physical therapists to make medical diagnosis, to prescribe and carry out treatment, and to prognosticate the results of their therapy.

If passed, the Board of Physical Therapy would consist of five therapists, two public representatives, a hospital administrator, and a state representative. Neither primary physicians nor specialists (such as physiatrists, orthopedic surgeons, neurologists, or neurosurgeons) would be on the Board. Therapists would practice in a vacuum without the benefit of x-ray diagnosis (they are not permitted to order such studies now), but they could utilize "screening" modalities that may prove costly and misleading without supervision. At present, third-party payers require written prescription of physical therapy by a fully licensed physician. Such a requirement would be eliminated.

Diagnosis is the primary skill of the medical doctor, which comes from many years of scientific and clinical education, intellect, talent, thoughtfulness, reasoned consideration, and experience. Treatment without diagnosis is a misadventure to which the citizens of New Jersey should not be subjected.

Picture the patient who develops an acute pain in the low back which radiates along the sciatic nerve distribution. Is it due to an acute herniated disc, diabetic neuropathy, entrapment neuropathy due to metastatic malignancy, or vascular occlusion of the vasa nervorum? Can a physical therapist make such a decision based on "screening tests?" Would not treatment without correct diagnosis delay appropriate treatment and perhaps injure the patient?

It is inconceivable that an enlightened Legislature would take seriously such an anticonsumer step backward, that will add uncontrollably to health care costs and will place our patients in jeopardy of both negligence and malpractice by ancillary personnel whose training in no way permits them to assume the awesome responsibility some of the practitioners of physical therapy think they want. All bright and thoughtful people wish to be independent, self-regulating, and free to determine their own destinies. However, physical therapists ought to reflect carefully upon the litigious nature of the American public before they don the mantle of independent therapy which this proposed legislation empowers.

Licensed physicians in New Jersey should recognize the obvious lack of merit in the proposed Physical Therapy Licensing Act of 1982 and the threat it poses to high quality health care. The organizations listed in the opening paragraph of this editorial oppose this legislation and have made their feelings known. Every physician should do likewise!

A.K.

Professional Liability Seminar

The positive response to the recent professional liability seminar at MSNJ headquarters makes an overview of the day's events imperative. The speakers were James E. George, M.D., J.D., Director of the Department of Liability Control; Peter Sweetland, President, New Jersey State Underwriters, Inc.; Irving Plain, M.D., and Joan Gelber, Esq., State Board of Medical Examiners; Warren P. Cooper, Chief Actuary, Property/Liability, New Jersey Department of Insurance; Frances K. Boronski, Esq., Chief, Civil Court Services Administrative Office of the Courts; and Vincent A. Maressa, J.D., Executive Director, MSNJ.

It is a truth universally acknowledged that malpractice will last forever. So we must deal with it. Malpractice is a deviation from the accepted standard of care. The two basic questions then are: "What is the standard of care?" and "Did deviation from the accepted standard of care cause the injury?" To prove such negligence, one must prove: 1) duty (on the part of the physician); 2) breech of duty; 3) causation (cause and effect between work and damage); and 4) damages (i.e. discernible injury).

The number of claims and suits is increasing. Peter Sweetland carefully listed the main reasons for claims and suits: complications from surgery; other procedures; difficulties with diagnosis; failure to diagnose; delayed diagnosis; complications from anesthesiology; and complications from treatment.

To avoid suit, Dr. George summed up a three-step procedure: keep up to date with medical research and techniques (through CME courses), keep good, clear medical records, and develop a rapport with each and every patient.

Dr. George is right. It comes down to just three main points. Though heavy documentation is a necessity and current medical technique a requirement, all speakers noted that there is no substitute for patient consultation time—because a physician is first and foremost a health care advocate.

The Department of Professional Liability plans another seminar on March 23, 1983, in an effort to reach those physicians who could not make this one. Be on the lookout for notices for the spring seminar. G.H.

Congress, JEMPAC, and MSNJ

In the first of a series, JEMPAC members met with Congressman Robert G. Torricelli (9th District). The meeting was called by the Congressman in an effort to discuss matters of mutual concern with others in Congress and with MSNJ. It is important for the Medical Society of New Jersey to have friends in government and such discussions only can help.

Frank Y. Watson, M.D., 1st Vice-President, and Past-President of JEMPAC, noted that 60 to 75 percent of MSNJ's activities are concerned with dealings with government. Watson stressed that because government now is making health care decisions that previously were made by physicians, MSNJ must be involved in the political arena.

For Congressman Torricelli, this meeting opened the door of communication. He stated that now is the time for representatives of the medical community to participate in political debate and to help congresspeople understand the complex system of health care.

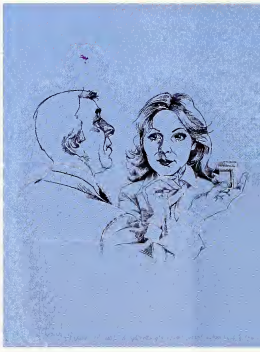
It is MSNJ's job to help provide the best possible health care to all citizens of New Jersey. Participation in the political process can help achieve such a goal. G.H.



Figure—Frank Y. Watson, M.D., Congressman Robert G. Torricelli, and Palma E. Formica, M.D.





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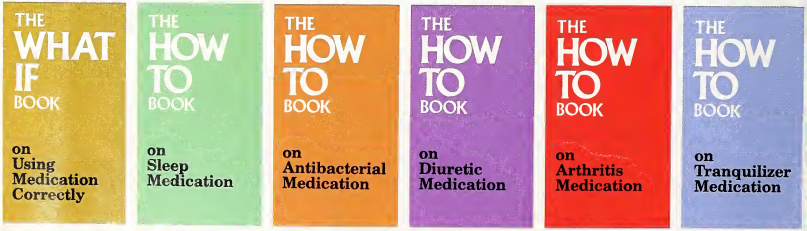
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Hospital Medical Staffs

One might ask whether there is a need for a section of *The Journal* to discuss matters of mutual interest and concern between hospital medical staff physicians and hospital governing boards. The answer clearly is yes and, in fact, such a section is long overdue and was mandated by MSNJ's House of Delegates by their adoption of Resolution #9 (1982).

Physician participation in the operation of the hospital corporation is an area of growing concern. Proof of this concern can be found in the recent results of AMA's *Fourteenth Periodic Survey of Physicians.*

The AMA survey revealed that 56 percent of office-based physicians spend more than 20 percent of their practicing hours in hospitals. Data further show that surgical specialties comprise approximately 30 percent of this office-based group and that virtually all of these physicians need a hospital affiliation to practice their specialties. (So said the AMA's board of trustees report on *Hospital Medical Staff Membership in the AMA,* which was presented to the AMA House of Delegates at its 1982 Annual Meeting.)

This survey also examined physician attitudes. More than half of the respondents indicated that they had detected a change in medical staff/hospital working relationships in the past five years, a change most physicians called negative. Physician respondents identified several medical staff/hospital issues as very important. Included among these issues were:

- Lack of medical staff voice in hospital planning.
- Lack of medical staff representation and voice in hospital governing board decisions.
- Effect of changes in hospital ownership on medical staffs.
- Competition between hospital ambulatory services and office-based practices.
- Hospital diversification into other profit-making activities.
- Closed medical staff arrangements.
- Interpreting and complying with JCAH standards.
- Role of nonphysician health care providers in the hospital.
- Interspecialty jurisdiction in delineation of privileges.
- Hospital cost containment.

This list is by no means exhaustive, but it does serve to highlight some of the key issues in medical staff/hospital relations. It is anticipated that these and other relevant issues will be discussed in future issues of *The Journal.*

We believe that medical staff members generally feel that they have little or no say in decisions made by the hospital corporation. Physicians usually attribute this reality to the fact that the hospital corporation does not want its medical staff to become too influential lest a delicate balance of power shifts to the favor of the medical staff. Thus, medical staffs usually have been underrepresented on hospital governing boards.

However, there has been another less obvious reason why hospital medical staff potential has not been achieved fully within the institutional structure. This handicap largely is due to the inherent structure of the medical staff and its political custom of "turning over" medical staff leadership at a frequency which impedes the development and maintenance of physician administrative skills and momentum. The hospital chief executive officer and his management team usually are constants in the medical staff/hospital equation. The board of trustees of the hospital corporation usually speaks with a unified voice. But the leadership of the medical staff usually changes at one- to two-year intervals.

The frequency of hospital medical staff leadership succession must slow down if physicians are to have any hope of effectively participating in the decision-making process within the hospital corporation. Retaining medical staff

*The material for this column was coedited by Arthur Krosnick, M.D., Editor of *The Journal,* MSNJ; Vincent A. Maressa, Executive Director of the Medical Society of New Jersey; and James E. George, M.D., J.D., Director of the Department of Professional Liability, MSNJ.

leadership for a longer period of time, perhaps three to five years, will give the hospital administration and governing body a chance to become better acquainted with medical staff leaders and vice versa. This will result in a more effective partnership with hospital leaders and should foster more informed and efficient decision making.

Despite the obvious advantages of such a change, there are significant physician factors that work against the concept of long-term medical staff leadership. These political factors revolve around the fear that longer terms tend to favor a few physicians and undermine sound democratic principles which require shorter terms of office, subject to periodic election in order to avoid a dictatorial arrangement. Some physicians strongly feel that the "other guy" should have his turn to sit in the leader's chair, i.e. the concept of "reward" plays an important role in medical staff politics.

Medical politics are not inherently "bad" but are a fact of life. However, hospital practice has changed dramatically in the past ten years and health care concepts are changing at an accelerating pace. It is very time-consuming to serve as a medical staff officer or committee chairman or member. Time is the one commodity which is short and hospital activities tend to cut into family and recreational pursuits.

All of these factors now require hospital medical staffs to reanalyze their structure, function, and administrative goals. Failure to do so and failure to develop up-to-date effective methods of medical staff operations will result in the inevitable erosion of the physician's influence within the hospital. An impressive array of nonphysician managers, such as administrative nurses and business administrators, coupled with the pervasive role of external influences, such as government and third-party payers, is altering the picture. Hospital medical staffs should not ignore these realities.

Current changes in hospital corporation procedure are not diabolical plots by the-administration and governing body to "control" the medical staff. Rather, they are state-of-the-art attempts by hospitals to stay alive and grow in the decade of the 1980s. Hospital medical staffs should be able to participate in this challenge as well. Failure to do so will be interpreted as medical staff abrogation of its share of the responsibility for the quality of health care and will create a vacuum which will be filled by nonphysicians.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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BRIEF SUMMARY
PROCARDIA® CAPSULES For Oral Use
(nifedipine)

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digitalis increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mid to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NOC 0069-2600-66), 300 (NOC 0069-2600-72), and unit dose (10x10) (NOC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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Trichomonas Vaginalis in Men

ROBERT E. FULLILOVE, JR., M.D., Newark*

The wide variations among the figures reporting the incidence of *Trichomonas vaginalis* in men are reviewed and discussed. A method for the detection of *Trichomonas vaginalis* and the possible clinical significance of an association of *Trichomonas* with other microorganisms are presented.

The question of the role of *Trichomonas vaginalis* as an etiological factor in infections of the male genitourinary tract is characterized by confusion and conflicting statistics. On the one hand, there are the studies by Bowie et al.,[1] Goldman,[2] Anderson and Weller,[3] Klousia et al.,[4] Holmes,[5] and Felman and Nikitas[6] that tend to indicate that *Trichomonas* plays a relatively insignificant role as a pathogen in the male. At least one study does not even mention *Trichomonas* in a discussion of nongonorrheal urethritis.[7]

On the other hand, studies by Crowley,[8] Bauer,[9] Feo and Fetter,[10] Verges,[11] Subiabre et al.,[12] and Watt and Jennison[13] suggest that the incidence of this infection in the male is at or near the incidence reported in the female. It is common clinical practice for gynecologists to prescribe specific medication for the sexual consorts of their patients on the assumption that they too harbor the parasites, whether or not they are detected in the male. Felman emphasizes the possible importance of the male as a reservoir for the organisms, whether or not they are symptomatic.[14] Swartz,[15] Ward,[16] and Bernfeld[17] also indicate the necessity for a thorough search for this parasite, regardless of the question of its role as a pathogen in the male.

PATHOGENICITY IN THE MALE

With respect to its pathogenicity in the male, Riba and Harrison[18] reported that 10 percent of their male patients with strictures of the urethra had *Trichomonas,* and Catterall[19] estimated that this infection is present in 12 to 15 percent of men with urethritis. Fisher's studies[20] suggested a possible connection between *Trichomonas* and epididymitis, and Sowmini et al.[21] as well as Felman[14] noted an association between *Trichomonas* and penile ulcers. Several studies have implicated *Trichomonas* as a possible factor in male infertility.[23,24] Elsewhere in the body, *Trichomonas* has been found in a case of meningitis[25] and perinephric abscess.[26]

Anatomical and physiological differences between the sexes probably account for the difficulty in detecting the organisms in the male and explain the apparent discrepancy in the incidence of infection reported in the sexes. Of paramount importance in this respect is the irrigating action of the act of urination in the male, a point emphasized by Catterall.[19] With this in mind, Feo used the first voided urine specimen of the day as a medium in which to search for *Trichomonas,*[10] but this method obviously is impractical for use with the office patient or the ambulatory clinic patient.

Concerning possible physiological factors, there is some disagreement as to the role of the prostate in *Trichomonas* infections. Crowley,[8] Watt and Jennison,[13] and Brown[22] believe that the prostate is the main site of the infection in men. Kohlicek and Stankova state emphatically that *Trichomonas* is not found in the prostate but solely in the

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urethra in the male;[27] they believe the signs and symptoms of prostatitis in the male infected with *Trichomonas* are due to toxic and possibly allergic factors resulting from the location of the organisms in the urethra.

LABORATORY DIAGNOSIS

The use of fresh ejaculated semen for the diagnosis of *Trichomonas* was advocated by the authors of several of the previously noted studies, but this method, too, is impractical for routine use in the office or the clinic. The general unreliability of the use of stained smears was mentioned by Bennett et al.,[28] Fleury,[29] and Perl.[30] Likewise, the use of culture media does not yield consistent results in the male. Culture media, as a routine diagnostic method, is mentioned by many investigators, but, in my hands, it has been disconcerting to note the frequency with which *Trichomonas* culture media, either freshly prepared or commercially available, will fail to show growth of the parasites even when they have been inoculated with specimens from men in whom the parasite is known to be present. Equally puzzling is the fact that *Trichomonas* sometimes will grow in the simplest media, such as transport medium or plain broth. The medias most often employed are variations of the one developed by Trussell and Johnson,[31] but it is obvious that other factors are important in demonstrating *Trichomonas* in specimens from the male patient, a point first emphasized by Crowley.[8] One such factor may be the presence of other microorganisms, I have observed that the presence of a concurrent infection with *Pseudomonas* organisms will produce an excellent growth of *Trichomonas* in a culture medium consisting only of a chocolate agar slant overlaid with physiological saline. This is somewhat similar to an observation of Roberts and Siklok who observed the occurrence of satellite streptococci in some cases of endocarditis.[32] These were microorganisms that would grow *in vitro* only in the presence of other bacteria, and the absence of the required contaminant would result in failure to detect the etiological microbe. The possibility that other microbes may play a role similar to *Pseudomonas* in the culture of *Trichomonas* is suggested by the findings of Vinai et al.[26] and Jitpraphai and Wise.[33]

"Any discharge or pyuria that becomes worse after treatment with these drugs should indicate to the clinician the need for a thorough search for *Trichomonas*."

A yeast contamination in actively growing *Trichomonas* cultures also has been noted. The deliberate contamination of the culture medium described has diagnostic possibilities but its usefulness in an office or clinic laboratory is restricted because of the difficulty of maintaining stock cultures of the required contaminant and because of the necessity of very strict controls since *Trichomonas* will grow sometimes on solid media and the original source of the exogenous contaminant may have harbored a *Trichomonas* infection. The addition of gentamicin, approximately 4 mg per 5 cc of liquid medium, enhances the growth of *Trichomonas* and the organisms sometimes will grow aerobically and sometimes anaerobically. The optimum temperature is 36 to 37 degrees. For an anaerobic environment, an airtight glass jar with a lighted candle is sufficient. The growth-promoting potential of gentamicin is interesting in that the use of certain drugs frequently prescribed for the treatment of urinary infections may exacerbate a *Trichomonas* infection. These drugs include aminoglycosides, ampicillin, cephalosporins, and sometimes sulfamethoxazole/trimethoprim. Any discharge or pyuria that becomes worse after treatment with these drugs should indicate to the clinician the need for a thorough search for *Trichomonas*.

DIAGNOSTIC PROCEDURE

The main focus in the diagnosis of *Trichomonas vaginalis* at present, must rest on the careful microscopic examination of wet smears of material from the genitourinary tract. I have found the following method to be effective as an office procedure. It is a modified combination of the methods of Ward,[16] Brown,[22] Crowley,[8] and Meares and Stamey[34] as modified further by Drach.[35]

Before voiding and before prostatic massage, the patient is made to lie supine on the examining table and a small quantity (1 to 1½ cc) of physiological saline solution gently is injected into the urethral meatus by means of a small, blunt-tipped bulb syringe. This is allowed to flow by gravity into a sterile container, but gentle milking of the urethra is done if necessary. This material is subjected to microscopic examination and culture. This supplants the usual first glass of urine specimen and has the advantage of avoiding the necessity for centrifugation and the possibility of severe alterations in the detectability of the parasite due to variations in the urinary osmolarity and pH. Bennett et al.[28] have emphasized that *Trichomonas vaginalis* is a very delicate, thin-walled protozoan that is injured easily. This procedure is carried out even in the presence of a frank urethral discharge, because the saline solution seems to be a better vehicle in which to demonstrate motility than a purulent discharge that sometimes may be quite thick and viscid. The patient then is asked to void in two glasses and these specimens also are subjected to microscopic examination and culture. Massage of the prostate then is done and the expressed material collected on a glass slide for wet smear microscopic examination, and another urethral washout is done in the manner previously described. This also is subjected to microscopic examination and culture. It must be emphasized that this examination must be diligent and thorough and that the microscopist must search not only for the rapid, whip-like motion usually associated with *Trichomonas,* but also for varying degrees of motility, ranging from an occasional lazy flip of a flagellum to a mere undulating membrane. Since the focus of this method is on the detection of a protozoan whose motility must be demonstrated in order to establish a firm diagnosis, its emphasis is different from the methods of Meares and Stamey and Drach's modification, as these investigators were interested in pathogens to be identified by culture. Since this method has been developed as an office procedure, it has not yet been subjected to a rigorous analysis as to effectiveness in comparison with other methods for detecting *Trichomonas.* This must await its trial on a larger scale than is possible in an office practice.

A review of the 300 male patients coming to my office with complaints requiring an evaluation as to the presence or absence of a lower urinary tract infection or with a history of contact with a possible source of a sexually transmitted disease, showed that 16 percent of these males harbored *Trichomonas vaginalis* in the lower urinary tract. Of these 46 patients, the diagnosis of *Trichomonas* was made and confirmed in 39 patients or approximately 85 percent by careful

microscopic examination and by the use of "contaminated" culture media in the manner described. In 5 patients or approximately 10 percent of the total number found to have *Trichomonas*, microscopic examination failed to disclose the microorganisms and they were detected by culture of the secretions obtained by the urethral irrigations described, both before and after prostatic massage. In 2 cases or approximately 5 percent, the organisms were seen on microscopic examination, but failed to grow on culture media.

SUMMARY

The purpose of this paper has been to point out the many unanswered questions pertaining to *Trichomonas vaginalis* in men and to emphasize the need for further research to better evaluate its role in sexually transmitted diseases.

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The Cry Spectrogram: An Aid for Analysis

CARL GUZZO, JR., JACK DEMAREST, Ph.D.,
MARILYN L. CANNON, M.D., West Long Branch*

The sound spectrograph provides a tool for analysis of infant cries. No single catalog of the characteristics of a spectrogram applicable to cries has been available to physicians. This paper presents a historical review of the study of infant cries and an atlas of the major acoustic features of cries.

Infant cries have intrigued mankind for centuries. The "birth cry," the first demonstrated behavior of the newborn, has been a topic of interest for poets, novelists, and philosophers. Crying is the infant state that creates the greatest anxiety and alarm in parents. Most parents feel compelled to determine the cause of the cry and find ways to stop it. Mothers especially are concerned about the infant who cries chronically; some mothers have indicated that their infants' cries do not seem "normal."

Physicians, through clinical experience, concluded that some cries pointed to abnormalities, e.g. cri du chat syndrome, cretinism, brain damage, and malnourished infants,[1-3] and may predict candidates for sudden infant death.[4,5] However, clinical impressions are not amenable to quantitative analysis; where these reports do occur, only scattered accounts provide useful scientific data.

Prior to the 1940s, scientists largely ignored the study of infant cries, concentrating instead on language development. Unfortunately, the bulk of this literature consists of semi-scientific observational studies of a biographical nature, typically limited to the vocalizations of one or two individuals. Gardiner's studies in 1832 were among the first to analyze cries objectively. He used musical signs to express the acoustic structure of crying, a technique that continued into the 20th century.[6] Darwin, in discussing the expression of emotions by men and animals, devoted a certain portion of his work to the screaming and weeping of infants, but he was concerned chiefly with the local anatomy and developmental physiology of speech production.[7] Many other studies attempted to analyze crying by representing the auditory characteristics in a system of shorthand or phonetic symbols, a procedure still used by some researchers today.[8]

Numerous problems arise in using musical, phonetic, or shorthand notes to record the sounds that infants make. Musical notation is useful in that it can provide a guide to the pitch and melody quality produced by the cry, but it fails to describe the nature of the phonemes in each sound. Phonetic analysis was made possible by the development of the International Phonetic Alphabet; however, it is impractical to try to express in adult sounds a vocalization of an infant prior to speech maturation. Infant utterances are not like any of the well-defined characters of adult language,[9] and there is no international phonetic alphabet for the sounds of a baby. Shorthand notes are the least reliable method for recording infant vocalizations due to the subjective nature of the record. Descriptions made using this method have included terms such as: "burred lip sounds," "happy intonation," a "labio-lingual sound," and "aaa, uttered with distinctive intonation." These notes are vague and of little use to all but the original notetaker. Most serious of all the criticisms that can be raised about these methods is the fact that they rely upon the auditory memory of the observer, a particularly

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unreliable process. Not only must one retain the sensory quality in memory long enough to transcribe it into musical, phonetic, or shorthand notes, but comparison at a later time requires the recall of an auditory image based upon these notes. Errors in transcription and in recall are typical even with simple, familiar sounds and infant cries are neither simple nor familiar to most observers. McCarthy stated the problem clearly: "Obviously, it is quite impossible to take down the sounds as they are made by the infant, in writing, in shorthand, or in phonetic system. They occur too spontaneously and too rapidly; they have no meaning to the experimenter, there is no conventional form for them which can be abbreviated, and probably most serious of all is the subjective factor of the experimenter's error of listing.[10]

With the invention of the phonograph by Thomas Edison in 1877 and the development of record cutting machines by the turn of the century, it became possible to record permanently and characterize the acoustic properties of infant cries. Flatau and Gutzmann of Germany made use of this technology to produce the first objective description of crying.[11] The procedure, however, did not provide as much information as might be expected. The machines were cumbersome, hard to operate, and expensive. The records, particularly the wax cylinders used on the Edison machines, lost fidelity after several replays. In addition, recordings were not made under natural conditions so that structural analyses could be complemented by contextural analysis of the cries. Dorothy McCarthy indicated that "although much progress has been made in mechanical and electrical recording, little has been done to apply these techniques to the study of infant vocalizations."[12]

SOUND SPECTROGRAPH

A major breakthrough came in the 1940s when Bell Telephone Labs developed the sound spectrograph. This instrument was designed to record complex audio frequency waves and reproduce them to provide a pictorial analysis of frequency and energy distribution against time. The major benefit of the spectrograph is that it translates the spectrum of sound into a visible picture so that it is as distinguishable to the eye as it is to the ear. Precise descriptions, therefore, do not require extensive training in phonetic or musical notation; one only needs to be able to distinguish one visual wave pattern from another. The recording reproduced on paper is called a spectrogram.

Sound spectrography first was used to investigate infant vocalizations in 1955. A.W. Lynip showed that the birth cry is irregular, long, and quavering with voice harmonics covering a range from 60 to 3500 Hz, but that within 24 hours crying became rhythmic and less intense, with more pronounced resonances.[9] Furthermore, he demonstrated what had long been suspected—that there were quantifiable differences between cries. The early infant biographers had conflicting views on the differentiation of infant cries. Some believed that the cries were merely reflexive,[13,14] others thought that they represented signs of suffering,[15] and several argued that different cries indicated loneliness, fright, hunger, or pain.[16,17] Dearborn indicated that by 2 to 3 weeks of age crying was differentiated according to cause, and that hunger, pain, and other motivational states could be distinguished in the auditory characteristics of the cry.[17] Others disagreed. Blanton noted that infant cries did not differ in timbre, pitch, and melody, and that the only difference between hunger, pain, and cold cries during the first months of life was the intensity of the sound.[13] Similar conclusions were drawn by Fenton[18] and Sherman.[19] Lynip's spectrographic analysis suggested that there were quantifiable differences between cries of hunger and pain, and his findings have been verified by several subsequent programs of research.[20-24]

Since the 1950s, there have been many contributions to the spectrographic study of infant vocalizations. Karelitz and Fisichelli, for example, compared recorded cries of normal and abnormal infants,[25] while Truby attempted to correlate patterns of sound cries with the infant's mouth and throat movements.[26,27] Lester,[2] and, more recently, Zeskind and Lester[28,29] have examined the cries of malnourished infants and the cries of infants with prenatal and perinatal complications. Most notable, however, are the Scandinavian studies by Lind, Wasz-Hockert, Michelsson, and their colleagues. Their extensive programs of research provided meticulously refined descriptions of infant cries and strong evidence for the value of spectrographic analysis in the diagnosis of infections and metabolic and developmental abnormalities.[3,20-23,30,31]

The two Scandinavian monographs by Michelsson[20] and Wasz-Hockert[21] provide the most detailed systematic catalogs of the acoustic attributes of cry signals available. These references, however, are not readily accessible to the physician and they contain extensive tabular analyses, making rapid referral to the acoustic features impractical.

It is our intention to simplify the characterization of the newborn infant cry to facilitate ease of utilization by other investigators and by physicians interested in using infant crying as a diagnostic tool. What follows is a spectrogram atlas of the basic parameters of infant cries.

MATERIALS AND TECHNIQUES

The cry recordings were made at the Jersey Shore Medical Center in Neptune and in a private home in New Jersey. Most of the cry signals were recorded from a normal, healthy, full-term female, but several cry characteristics (Figure 5) were taken from the signals of other infants. All vocalizations were recorded on a Sony TC 142 cassette tape recorder with a Shure Unidyne III, Model 545D directional microphone. For each of the recordings, the microphone was held within 1.0 to 1.5 inches of the baby's mouth. In order to obtain all of the cry features in this atlas, it was necessary to record the infant vocalizations in several different contexts at various ages. Hunger cries were defined as vocalizations recorded at 4 hours ± 30 minutes after the previous meal and immediately terminated by acceptance of the bottle. Pain cries were elicited by a sharp finger flick on the sole of one foot. General distress or arousal cries were defined as any nonspecific vocalizations unrelated to pain or hunger. Recordings were made at ages 1, 2, 3, 7, and 11 days old. Although it is difficult to be certain of the functional role of each of the specific cries that were recorded, these operational definitions are fairly precise and adequate for obtaining the diversity of the spectrographic features reported.

Spectrograms were produced on a series 700 sound spectrograph* located in the Department of Psychology, Monmouth College.** For most analyses, a 300 Hz wide band filter was used, although several signals (Figure 5) required a 45 Hz narrow band filter. Procedural details of sound spectrography can be found in Potter, Kopp, and Green.[32]

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**Portions of this research were made possible by a grant from Monmouth College.

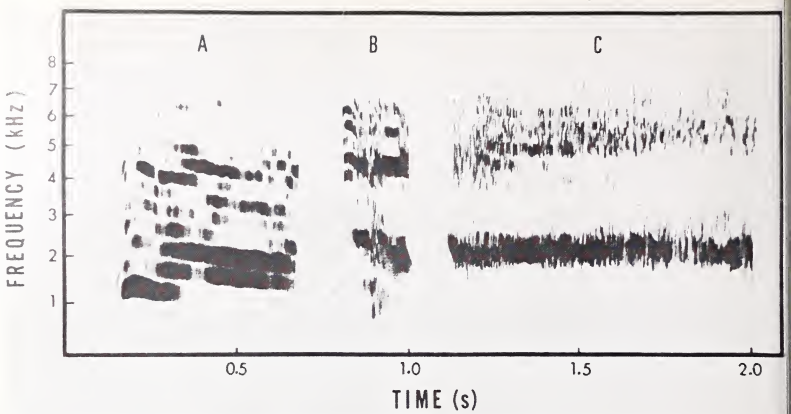


Figure 1—The voice characteristics of a healthy infant are different gradings in the relative purity of the formants of the cry signal. A: Voiced phonation; B: Half-voiced phonation; C: Voiceless phonation.

The spectrogram is a visible picture of sound frequency and sound intensity over time. Frequency (pitch) is measured along the ordinate in kilohertz (kHz) and time is measured along the abscissa in 0.1 seconds. The vocal tract resonance is displayed in a spectrogram as broad wave bands called formants, the lowest of which is the fundamental frequency. Intensity of sound is reflected in the relative darkness of the formant, darker bands represent higher intensity signals. Many signals typically included overtones that appear as a series of identically shaped formants at higher frequencies, growing fainter with distance from the fundamental frequency. The spectrograms presented in this paper incorporated a logarithmic scale on the ordinate to emphasize the lower frequencies.

SPECTROGRAM CHARACTERISTICS OF INFANT CRIES

Four categories of spectrogram features relevant to infant cries can be distinguished. Within each category several different sound characteristics are found. The category labels used here are similar to those found in other publications[20,21] and include temporal features, voice features, melody types, and ancillary features.

Temporal characteristics refer to measurement along the abscissa of the spectrogram. We distinguish three types of temporal features:

1. Latency Period: This is the time interval between the presentation of a discrete stimulus and the onset of the first cry signal. In this altas, latency period also refers to the interval between the end of one complete cry signal and the onset of another.

2. Vocal Pause: In the case of discontinuous signals, this is the time between the termination of one component of the cry signal and the onset of the next component of the signal. Vocal pause is distinguished from latency period when cry signals consist of multiple components. Therefore, it is necessary to determine if a cry regularly contains a series of distinctive phonations in a characteristic sequence. Such a sequence would represent a discontinuous cry signal.

3. Signal Duration: This feature is the duration of the cry signal in 0.1 seconds. Some cry signals may be composed of two or more components, and measuring the signal duration from the onset of the first component to the termination of the last component would include the vocal pause between signals. We have found that measuring signal duration in this way can produce wide statistical variance, and, consequently, it is not a useful feature. It is more practical to measure separately the duration of each component of a cry signal and each vocal pause within a signal.

Three different gradings were made from the spectrograms: voiced, half-voiced, and voiceless phonation:

1. Voiced Phonation: This is a signal consisting of pure tones of a single frequency which causes a repetition of wave patterns. An example of voiced phonation is shown in Figure 1A. The lowest waveform is the fundamental frequency and harmonic overtones are represented by parallel formants at higher frequencies.

2. Half-voiced Phonation: This sound contains the characteristics of voiced phonation broken up at intervals by segments of noise, i.e. blurred signal. Figure 1B is an example of half-voiced phonation.

3. Voiceless Phonation: This consists of an indistinguishable blur of sound vibrations without a fundamental frequency or harmonics (Figure 1C).

The different melody types are defined in accordance with Wasz-Hockert et al. as a change in the pitch level in excess of 10 percent during more than 10 percent of the signal duration.[21] Durations are typically 0.4 seconds or longer. The basic melody types are shown in Figure 2. Rising is an increase in the fundamental frequency over the duration of the signal (Figure 2A). Flat signals (Figure 2B) are wave forms in which the fundamental frequency does not change. Falling is a decrease in the fundamental frequency over the length of the cry (Figure 2C).

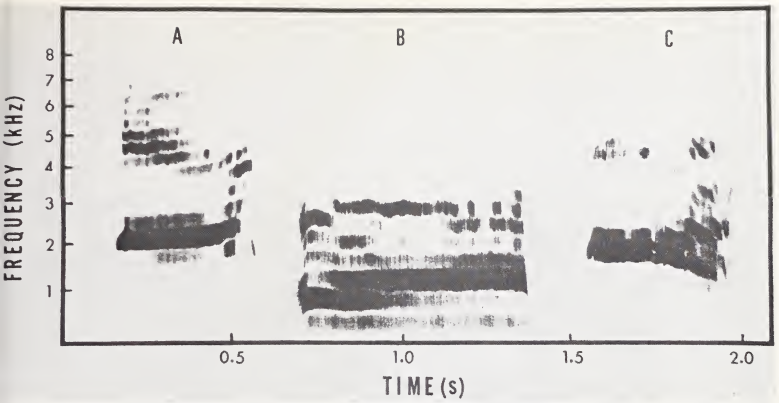


Figure 2—Melody types represent changes in the pitch level of the formants. A: Rising; B: Flat; C: Falling.

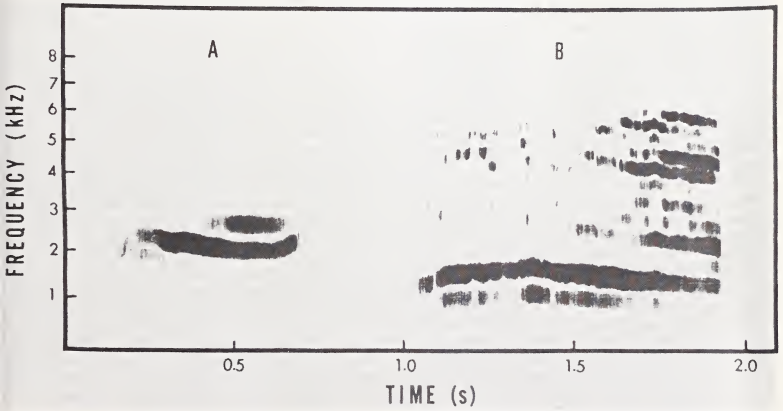


Figure 3—Complex melody types are combinations of the basic melodies in a single formant. A: Falling-rising; B: Rising-falling.

More complex melody types are simply combinations of these basic types (Figure 3). The pattern shown in Figure 3A is a falling-rising type of melody. The fundamental frequency initially decreases and then begins to increase without a voice pause. A rising-falling melody type is provided in Figure 3B. The fundamental frequency initially increases and then begins to decrease without a vocal pause. Also, it is possible for an infant cry to have no melody form. This occurs when the cry is totally voiceless and when it contains only glottal plosives or shorter sounds less than 0.4 seconds in duration.

Ancillary characteristics are distinctive features in the spectrogram that have been grouped together merely for convenience. They have no necessary relationship to one another. Several of these characteristics went undetected when spectrograms were made with the 300 Hz wide band filter but they became apparent when a 45 Hz narrow band filter was used. Four features found using the wide band filter are shown in Figure 4; these include glide, shift, glottal plosives, and vibrato:

1. Glide: This is a rapid change in pitch of 600 Hz or more in less than 0.2 seconds (Figures 4A). Glide is distinct from a melody type in that the change in the fundamental frequency occurs rapidly. Melody types typically are signals with longer durations in the range of 0.4 seconds or more. A

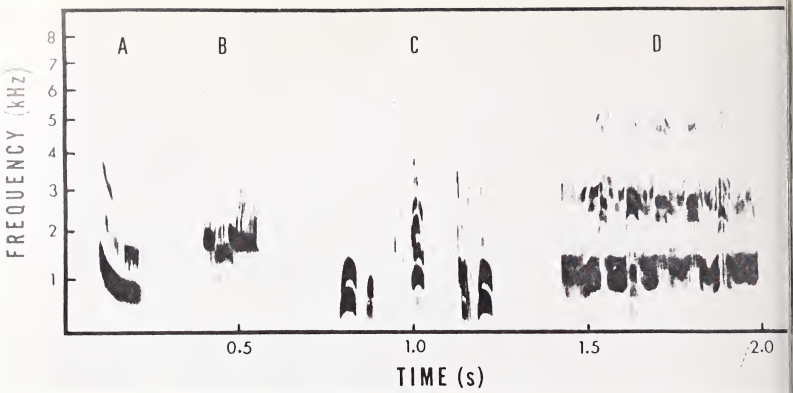


Figure 4—Ancillary characteristics are distinctive features. A: Glide; B: Shift; C: Glottal plosives; D: Vibrato.

glide is a graded change and is distinguishable from a shift.

2. Shift: The shift is a sudden, instantaneous change in pitch level. The change may occur at any point during a cry signal and may raise or lower the fundamental frequency. An example of a downward shift followed 0.1 second later by an upward shift is shown in Figure 4B. Note the brief downward glide after the upward shift. The new pitch established by the shift may end as it does in this figure or it may continue, resulting in a melody type. Shifts during infant cries occur irregularly.

3. Glottal Plosives: Short, sharp phonations of less than 0.2 seconds are called glottal plosives. They are typically but not always characterized by an inverted U-shaped appearance in the spectrogram, representing an extremely rapid rising-falling change in pitch. Three examples of glottal plosives are shown in Figure 4C, the first and third of which appear almost identical. Note, however, that the first example consists of two plosives, the second less distinct than the first and the third example consists of two plosives, the first less distinct than the second. The middle example of a glottal plosive has a higher fundamental frequency than the others (approximately 1000 Hz) and it includes harmonic overtones distinguishable up to 3500 Hz. Wasz-Hockert et al. divide infant cries into three groups on the basis of glottal plosives: those in which plosives occur in the same cry signal with other types of vocalization, those which consist entirely of glottal plosives, and those that contain no glottal plosives.[21]

4. Vibrato: These are wave-like changes in pitch occurring rapidly and frequently throughout the formant structure. Figure 4D provides an example of a segment of vibrato taken from a long duration hunger cry. Breaks in the fundamental frequency at 1000 Hz simultaneously are matched by an increase in the intensity of the sound at 2500 Hz (and in the overtones at 5000 Hz). Similarly, diminution of the intensity of the 2500 Hz sound is matched by greater intensity of the fundamental frequency. Each rapid oscillation in the sound pattern takes less than 0.1 seconds, and is repeated a number of times.

One advantage of a wide band filter is that it provides information about the relative intensity of the signal and the degree to which harmonic overtones are incorporated in the signal. The 45 Hz narrow band filter functions to screen out much of this information. However, the narrow band filter has the advantage of making certain spectrogram characteristics more distinct. Several characteristics found in pain cries were detectable only when the 45 Hz filter was used. These features are shown in Figure 5 and include shifts, biphonation, and vocal fry:

1. Shift: This characteristic was described and is included here to show the difference between a spectrogram made using a 300 Hz wide band filter (Figure 4B) and one produced with a 45 Hz narrow band filter (Figure 5A). The upward shift in pitch in Figure 5A is sudden and instantaneous, occurring in the middle of the cry signal. Note that it is much easier to distinguish the shift with the narrow band filter since the formant structure is defined more precisely.

2. Biphonation: This refers to signals produced from two separate sound sources in the same vocal mechanism. The spectrogram characteristic representative of biphonation is the occurrence of a simultaneous series of formant lines that is not parallel to the fundamental frequency. Biphonation is shown in Figure 5B. The fundamental rising-falling melody type at 1500 Hz and the harmonic overtones do not correspond with the less intense formant lines at frequencies of 2100 Hz, 2700 Hz, and multiples of these. The 2100 Hz tone is flat and not parallel to the fundamental frequency. The 2700 Hz tone begins with a forked formant line which, in itself, implies two different sound sources. Michelsson makes a distinction between biphonation and double harmonic break.[20] In the former, the formant lines are not parallel, but the lines do run parallel to one another in double harmonic break.

3. Vocal Fry: Vocal fry, also called "glottal roll" or "creak"[20,21] consists of vibrations in a low frequency range with no distinct overtones, occurring most often at the end of voiced phonation. The vocal fry shown in Figure 5C was produced immediately following a voiced falling melody type. It also has been described as a trembling, narrow set of

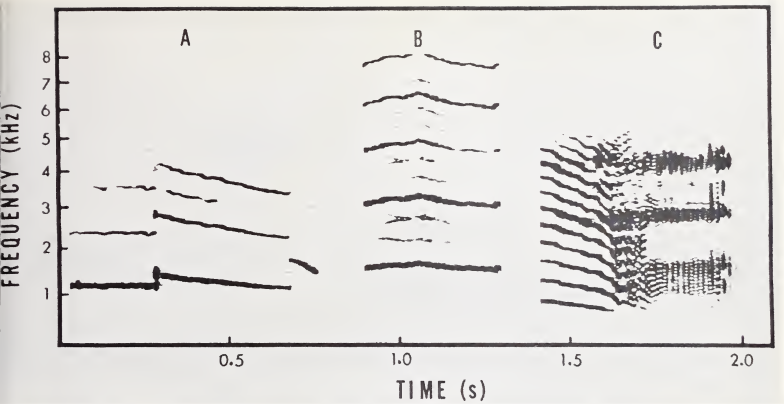


Figure 5—Ancillary characteristics that were detected with a 45 Hz narrow band filter. A: Shift; B: Biphonation; C: Vocal fry.

harmonics of a low intensity[21] caused by low frequency vibrations of the vocal cords such that the movement of individual cords can be heard.

In addition to these characteristics of the spectrogram, several other parameters of infant crying bear some consideration. The minimum and maximum pitch level, for example, have proved to be distinctive features in contextual cry analysis. Pain cries were shown to produce a much higher mean maximum pitch than other infant sounds and hunger cries were shown to exhibit the lowest mean minimum pitch.[21] The pitch level in each case was measured from the highest and lowest point of the voiced aspect of the cry. Another characteristic of complex cry signals is the subharmonic break. This is a pause or break in the normal spectrum of a fundamental and its harmonic such that the middle range of resonance frequencies is not reproduced in the spectrogram. An example of subharmonic break is provided in Figure 6.

CASE REPORT

Utilization of this spectrogram atlas for analysis and diagnosis of infant cries is reasonably straightfoward once the reader has become familiar with and able to distinguish between the different visual features. Analysis is simplest if each attribute is examined separately; however, a more detailed assessment of crying would require multivariate analysis. In this paper, we are concerned primarily with providing a simple reference tool for use by physicians and researchers; therefore, only the univariate analysis will be described.

In Figure 6, a sample cry pattern is examined to demonstrate how univariate analysis of infant vocalizations might be performed. The cry pattern selected for this purpose is the hunger cry of an 11-day-old healthy, female infant. The recording was made in a private home immediately before the infant's normal feeding time. The baby had been feeding on a regular 4 hour ± 30 minute cycle for at least two days prior to the recording and her behavior in the intervening periods was not unusual. The recorded segment of the cry began within one minute after onset and continued for 30 seconds. At the end of this time, the infant was picked up and held by her mother, her diaper was examined, and shortly thereafter the bottle was offered. The cry was classified as a hunger cry because it continued when the infant was held, it ceased immediately when the infant eagerly accepted the bottle, and no other sources of discomfort were apparent.

Figure 6 shows 2 seconds of the hunger cry pattern. This particular segment was selected for the variety of features it includes, but the general shape of the spectrogram is similar to other segments of the 30-second recording.

The hunger cry begins with a pair of glottal plosives, the second more distinct than the first. There is a vocal pause of 0.4 to 0.5 seconds between the second glottal plosive and the principal cry signal. (The spectrogram has been spliced at this point to fit all the information from this hunger cry in the Figure.) The duration of the principal signal is approximately 1.5 seconds.

Most of this cry consists of voiced phonation; however, the segments from 1.1 seconds to 1.3 seconds are composed of voiceless phonation, and the segments between 1.3 and 1.6 seconds contain gradings of half-voiced signal. Other 2-second samples from the original recording are voiced at this point, so the voiceless and half-voiced features are not characteristics of all hunger cries.

The glottal plosives by definition have no melody type but the principal signal contains a complex mixture of melodies. The fundamental frequency occurs at 1000 Hz and begins at 0.4 seconds with a flat melody type. The flat portion of the signal ends at 1.0 seconds, and at least a brief section of this is composed of vibrato. A second formant at a higher frequency (2500 to 3000 Hz) begins at approximately 0.5 seconds and extends to the voiceless phonation at 1.1 seconds. It appears that this is a biphonation since it does not run parallel to the fundamental frequency, especially at the onset where the signal is least intense. At 0.9 seconds the signal bifurcates, the lower pitch (2000 Hz) remaining flat but voiceless, and the higher pitch rising in melody type until it too becomes voiceless at 1.1 seconds. It is difficult to be

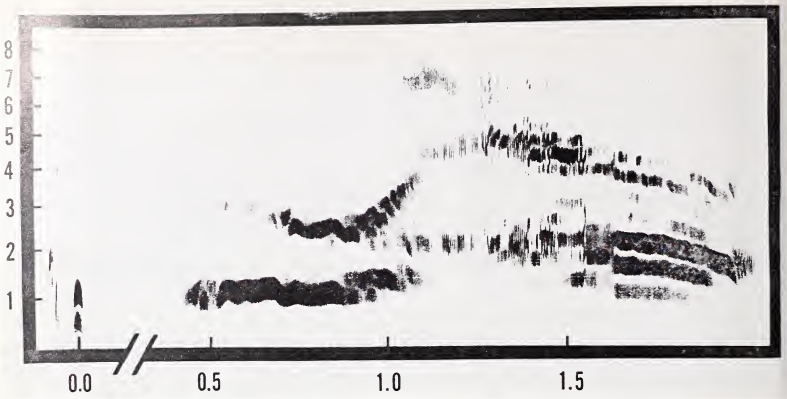


Figure 6—The hunger cry of an 11-day-old healthy infant.

sure from this portion of the spectrogram since the sound is losing its voiced characteristics, but it appears that the rising melody is due to a series of upward shifts.

Between 1.0 and 1.1 seconds the maximum pitch of the voiceless portion of the spectrogram is seen at 6000 to 7000 Hz. Note also that the minimum pitch is produced by the glottal plosive at 0.0 seconds. In the process of photographing the original spectrogram some of the low intensity signals were lost, and one of these was located in the area just before the maximum pitch. The signal began at approximately 0.7 seconds within the 7000 to 8000 Hz frequency range and terminated at the point of maximum pitch. It describes a falling melody type. In examining the relationship between the flat melody of the fundamental frequency, the rising melody of the second formant and the falling melody of this high-pitched, low-intensity signal we find a pause or break in the normal sound spectrum such that the middle range of resonance frequencies is not produced. This condition is called a subharmonic break, and is caused by the absence of the vocal cavity necessary for producing these frequencies.

Following the segment of voiceless and half-voiced phonation the voiced signal reappears at 1.6 seconds with a series of harmonics. The final portion of the hunger cry is a falling melody, terminating at 1.9 seconds. At the very end, the signal appears to glide downward several hundred Hz. This particularly is noticeable in the overtone between 3000 and 4000 Hz, but it is masked to some degree by the voiceless phonation ending the 1500 to 2000 Hz harmonic.

The univariate analysis of this hunger cry provides a number of distinctive features that now can be used for comparison with other hunger cries from the same infant, hunger cries from other infants, other types of cries, and cries from infants at risk. There are limitations in this technique. For example, it is not possible to be entirely certain that this specific cry is indeed a hunger cry. Although other sources of motivation other than hunger may have been excluded as far as possible, one never can be sure of the exact nature of any cry. The functional classification is, at best, a reasonable hypothesis about one of the possible causes of this particular behavior. Another problem is the subjective nature of classifying many of the spectrogram characteristics. At what point does a series of shifts become a glide? How much wave-like change in pitch is necessary for vibrato? When, precisely, does half-voiced phonation become voiceless? These and similar questions cannot be answered quantitatively and must depend on the qualitative judgment of the investigator. It has been shown, however, that with experience good interobserver reliability in making these judgments can be found.[21] Given the simple descriptions and visual examples in this atlas, even the most inexperienced individual can become adept at interpreting spectrograms of infant crying within a short time.

SUMMARY

This paper reviews the major historical developments in the studies of infant cries and sound spectrography. An additional purpose is to clarify certain parameters that can be helpful for further studies. Spectrogram characteristics are presented in four categories: temporal features, voice features, melody types, and ancillary features. A sample cry pattern of a normal healthy infant is included to demonstrate how analysis of infant vocalization might be performed.

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REVIEW ARTICLE

Death and Dying

EDITH T. SHAPIRO, M.D., Englewood*

Great popular interest in death and dying has been brought about by the uncertainties and the challenges of our times. Our death systems (beliefs and rituals) which are necessary to contain the universal dread of death have failed to function. Physicians are the centerpiece of dissatisfaction because advances in medicine have changed the circumstances of dying and medicine has failed to deliver on the promise of eternal life.

The following anecdote reflects the current myth that death is natural and ennobling, except for overbearing doctors who arbitrarily spoil it for their hapless patients.

> "A habitually helpless, frivolous woman seemed unaware of her fatal illness. However, one morning she knew that she was dying and with the most lovely smile and shining eyes she summoned her family to say goodbye. But since this was the middle of the 20th century, the dying person could no longer be sure of being left in peace . . . . The doctor arrived, flew into a rage, rushed into her room, hypodermic needle in hand . . . She opened her eyes and with the same brilliant smile whispered, "Thank you, Professor." Tears sprang to the doctor's eyes and there was no mention of an injection. He left us as a friend and ally and his patient continued the peaceful sleep from which she did not awaken."[1]

Writing about death has become fashionable. In a telling obfuscation in the name of clarification, a new term has been invented. The "thanatology" shelf in the local library almost is as long as the "sex" shelf, but much of this literature has a hidden purpose: death will be talked about but with its sting removed. If there is something wrong with death, it is not its intrinsic unacceptability to human consciousness, but what contemporary medicine has done to render death frightening and alien.

We must try to set straight the record, to review what we know and feel about death and dying, and to determine the responsibility of the physician with regard to death.

THE PROBLEM OF DEATH

We know intuitively what death is. It is the cessation of life, growth, and self awareness. Death always has been feared by man; it is "a scandal."[2] Death is the "worm at the core," the true essence of man.[3]

Recently, a woman who had cancer planned her suicide, had it videotaped, and showed it on public television. The woman had been active in an euthanasia group and had long proposed to take this step. The New York City Medical Examiner stated that the patient might have been overly pessimistic about her prognosis. Television critic, John O'Connor, commented that the patient stated that she had resolved to die before she experienced one minute of pain; Connor was discomfitted by death in the service of pleasure.

But if the hedonist cannot abide life with pain, what about life with the painful knowledge of mortality? Writer Albert Camus saw human existence as a "show" in which "absurdity, hope, and death carry on their dialogue."[4] Knowing that we are mortal, should we live in defiance, or hope, or take matters in our own hands and kill ourselves? "To be or not to be" is answered in the affirmative by human society.

Death systems, whose function is the preservation of life, evolve. But, from time to time in the history of our species, our defenses against the despair of death failed and death threatened to overwhelm all life.

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After the shock of World War I, Freud proposed that death was natural, that unconsciously man sought death. Through his studies of masochism, traumatic neuroses, and war, Freud discerned thanatos, a psychological death drive that parallels and always defeats eros, the life instinct.[5]

Whether a manifestation of an intrinsic desire for death or an aberration of the life instinct in times of vulnerability, death lures us with its siren song of false promise. The Black Death Epidemic during the Middle Ages collapsed contemporary defenses against death and resulted in death-seeking behaviors, the Inquisition, flagellants, witches, and vampires.[2] Alvarez wrote about epidemics of self-sacrifice among Christian martyrs that were so alarming the Church reversed itself on the value of martyrdom and forbade its provocation.[6]

It has been suggested that our own era resembles the Middle Ages and other times of social disorganization.[2,7] Science has let us down, atomic power threatens the survival of all humanity, and sociocultural mores and ethical guidelines are collapsing. The long shelves of thanatology books in our libraries, the public suicide previously described, and the increased tolerance for drug abuse are cited as evidence of conscious and unconscious death-seeking behavior. In the Middle Ages, the motive was salvation, but in our own time it is a paradox: death is sought because we have little tolerance for pain. Whatever the motive, the immediate outcome is the same: tragic and premature waste of individual life and a threat to the survival of mankind.

A literature on death began to develop a few decades ago, a reaction, in part, to the denial of death that characterized much of the 20th century.[23] Since the denial of death made dying harder for some people, bringing the skeleton of death out of the closet was a good thing. This was stage one.

We now are midway into stage two, where death has become a fad. A monster with its fangs ostensibly removed, it threatens to metamorphose into an enchanter whose charms we might seek. We need to examine death and dying from several perspectives: as individuals who need to resolve these issues for ourselves and as physicians whose tasks inextricably involve us in the deaths of others.

EXPERIENCE OF DEATH

What is known about the experience of death? At about age ten, we accept death as individual, final, unaffected by our behavior.[8] It is a cognitive acceptance that does not connote compliance. We accept the existence of a mystery; but continue to try to unravel it. There are accounts in both scientific and lay literature that claim to describe a return from death. There are consistent descriptions of out-of-body experiences, long tunnels with lights at the end, and encounters with deceased family members and different deities. Lepp, a Catholic theologian, priest, and psychoanalyst pointed out that these accounts are unreliable since these individuals did not die.[2] Lepp remarked that Lazarus who showed signs of putrefaction when he was resurrected after being buried for three days probably was dead, but Lepp points out that this solitary witness is most discreet and says nothing about what it was like to have been dead. Lepp suggests that in this era of "triumphant realism" we may have to return to mysticism and poetry for answers; to date, mystics and poets alike have reflected views particular to their time or have backed away from describing death.[2]

John Donne assured us with his words: "One short sleep past, we wake eternally/And death shall be no more/Death thou shalt die."[9]

Dylan Thomas sounded a defiant note: "Do not go gentle into that good night,/Old age should burn and rave at close of day;/Rage, rage against the dying of the light/Though wise men at their end know dark is right/Do not go gentle into that good night."[10]

FEAR OF DEATH

Much of the literature about death deals with people who know they are dying, but whose death is not imminent so they have time to contemplate death. Although studies on "normals," i.e. people who are not in immediate danger of death, also have been done, much of the discussion about effects associated with thoughts of dying comes from studies of this population.

Individuals who were dying described the experience as uncanny, as something unfamiliar in familiar surroundings, as an invasion by an alien force.[8] Some spoke about being trapped in reality; that everything would be the way it is; that the future already has happened; there was a loss of the sense of ongoingness that is characteristic of life.[8]

There actually are several fears, rather than a single fear of death. The fear of fear of death testifies to our hypocrisies. A mature person is not supposed to be afraid of death. Thomas Mann in *The Magic Mountain* has a physician say to a struggling and protesting dying patient, "Do me the favor not to behave like that."[11]

The fear of extinction is said to be unique and undescribable. The fear of being simultaneously alive and dead —trapped alive in a coffin—is another distinct affective experience.[8] Charon described four fears: fear of what comes after death, fear of dying, fear of ceasing to be, and fear of the dead. He said our culture and personality type determine which component predominates in a given individual.[12] For example, people who characteristically worry about tomorrow, worry most what happens after death. Others who fear suffering may fear the experience of dying and prematurely may terminate their lives.

"Science has let us down, atomic power threatens the survival of all humanity, and mores and guidelines are collapsing."

Death-related fears classified by Kastenbaum and Aisenberg are fears of dying and of afterlife and extinction. Further they are subdivided into fears of our own death and fears about the deaths of others. There are fears of personal suffering, indignity, vicarious suffering, disintegration, punishment, rejection, and loss of relationships which are present in different combinations. Again, depending on personality factors, some persons' fear of dying is colored by fear of dependency; for others personal suffering is easier to bear than vicarious suffering.[8] To offer appropriate support to a dying person, it is vital to recognize which of these fears is preeminent.

Contrasting findings suggest old people do not fear death particularly and, conversely, old people fear death but practice denial successfully.[8] One author finds that Americans, contrary to popular belief, are accepting of death.[8] Except for schizophrenics, people with psychiatric symptoms resemble normal people in their attitudes towards death. Searles believed that schizophrenia is a reaction against fears of death and that these patients experience themselves as

already dead to avoid facing death.[13]

Freud believed that man cannot conceptualize his own death, that he practices denial very successfully, and that expressed death fears really are fears of separation, i.e. a form of anxiety that can respond to therapy.[5] In this regard, Beigler claimed to be able to distinguish true fear of death from a death phobia and to use the presence of true fear which he equated with intuititon of real danger to predict death successfully.[14]

There are both scientific and popular accounts of correct premonitions of personal death and also of individuals who appeared to have willed their own deaths and the deaths of others. Neuroendocrine mechanisms have been proposed to explain some of the data.

Any discussion of the fears of death discloses the psychological mechanisms used by the individual to combat such fears. Denial, intellectualization, sublimation, and other defenses also are employed by the healthy, sick, young, old, and those close to death to palliate the fears. People who have been told that they are dying are said to utilize particular patterns of defenses. Kubler-Ross described dying as an orderly succession of universal coping maneuvers, denial, anger, bargaining, depression, and acceptance, that in "normal" circumstances, i.e. in times different from ours, resulted in calmness before death.[15]

Vanderpool said it is somewhat trivial to characterize death as a syndrome; there are four phases: detachment, disengagement, exhaustion or depression, and then followed by acceptance.[16]

Kastenbaum and Aisenberg describe alternative sequential but, at times, concurrent responses to death. They claim that there always is fear at expectations of one's own death, but that sorrowing is characteristic in anticipating deaths of others.[8] Fear is self-limiting and is followed by other attitudes of control, legacies, monuments, children, and lasting works. As death draws closer, there is an alteration of defenses, and death is experienced as something internal with an emergence of a sense of participation rather than overcoming.

All these authors qualify their remarks by saying that there are as many ways of dying as there are of living. These variables must be appreciated if death is to be made easier for the dying. There is a consensus in the academic literature that our current societal defenses against death, which are crucial to maintain individual defenses, are haphazard and fail us. In a well-integrated society, death systems consentually are validated and shared.

DEATH SYSTEMS

Aries infers from documents, fables, and tombstone inscriptions that for over one thousand years of European history there have been successful death systems which rendered death matter-of-fact and "tame." Aries discovered four main themes that recur through history and confer special characteristics on death systems in different versions. The four themes are awareness of self, defense of society against untamed nature (ecstasy of love as well as agony of death), belief in afterlife, and belief in the existence of evil.[1]

Only in the predawn of history and again in recent history was death wild, savage, untamed, and to be avoided at all costs. Motives and circumstances differed but the end result was the same—the dying were shunned. Where primitive man avoided death because he feared evil, modern man avoids death because of the importance of individualism, a sense of increased control over nature, and the lessening of social instincts. Changes in pattern, Aries says, occur because of spontaneous insights which erupt from a collective unconscious or through environmental effects.

Primitive people considered death unnatural and savage. Death was attributed to evil spirits and surrounded by taboos and prohibitions. Early consciousness was tribal. Since maintaining the integrity of society was primal, fear of death was fought with group rituals such as cannibalism or naming children after the dead. Burials were perfunctory and far away from the sites of the living. As individual consciousness emerged and the individual became more distinct and important, deathbed rites became prevalent. The dying person was maintained in the community and made farewells—but the emphasis still was on maintaining the integrity of the group. Mourning rituals reconstituted society and freed its members to move on to the tasks that assured the continuity of the species.

Until approximately the 11th century, the individual was safe but blurred; death was perceived as a sleep-like state with vague expectations of resurrection and life to come. With continued strengthening of individual awareness, the beyond was "colonized like some new continent."[2] The upsurge of individualism aroused interest in love and sexuality as well as in death; this led to a split between body and soul, as well as more elaborate burial customs. The body now was interred decently but still remained consigned to a vague resurrection. The soul was preserved, emerging triumphant and radiantly alive.

"The physician must respond when new challenges have been presented and must acquire new skills appropriate to the situation."

The Black Death epidemic of the 14th century temporarily strained the death systems; in reaction, a theology of death developed that stressed the horrors of final agony and predicted eternal damnation in hell for all except the extraordinarily ascetic. Death-seeking behaviors followed.

The birth of science in the 17th century was a turning point, a prelude to modern attitudes about death. In an outburst of "naive optimism," it appeared that death itself would be vanquished.[2] Death could be acknowledged as an adversary, because death would die—literally. Death became untamed, remote, and imminent, but no longer to be avoided. Death would be confronted and defeated.

In the 18th century there was a brief detour, an interval of romanticism. "Others" became the focus of death systems and individualism was transformed into "passions towards loved ones without limit or reason."[1] Death came to signify reunion with the beloved; hell disappeared from reckoning. During this time, the nuclear family was born.

In the first half of our century, the belief in afterlife waned. The concept of evil was displaced by theories of solvable social problems. Preeminent in our psychological negotiations with the awareness of death had been a strong sense of individualism, and the continued drive to master nature. Death, since it remained implacable and unconquerable, was treated as an aberration that had to be denied, avoided, and nullified.[1]

These same facts were interpreted somewhat differently by those still optimistic who felt that benevolent forces, dynamic progress in science, economics, and social and political theory which have exalted the worth of the individual and have provided an increased sense of control over the environment, brought about a great increase in life expectancy, diminished exposure to death, and rendered it less familiar. In this context death has become irrelevant and also somehow shameful.[2,17]

Within the last 20 years, a consensus has developed that while the human life span most certainly will increase, there always will be an end to individual life.[18-20]

The outpouring of writings on death is a reaction to this insight. This brings to physicians a challenge: as individuals in a culture we must join with others in the resolution of the dilemma of death and in the building of adequate death systems. Physicians also must protect themselves and their patients from factitious answers.

Carl Jung, in an essay on the collective unconscious, speaks of a universal magical power, vested in soul, spirit, God, fertility, magic, prestige, and medicine."[21] If such power indeed is inherently attributed to physicians in our culture, then perhaps some of us did become doctors to gain mastery over inordinate fears of death. Feifel, who compared physicians, medical students, seriously or terminally ill patients, and controls, seems to think so.[22] To be asked to seek encounters with death, rather than to busy ourselves to sustain life, may strike at the roots of some vital defense against the existential dread of death.

It is unfair to be asked to do this. The anecdotal physician who rushes in with his hypodermic needle to the side of a dying woman is behaving with great appropriateness—that is, after all, why he became a doctor. Preparation for death is the task of theologians and philosophers, family, and friends. But, contemporary circumstances place the patient far away from these traditional supporters, and surround him or her, sometimes exclusively, with physicians, nurses, and other medical personnel. Given that context, the physician must respond when new challenges are presented, and acquire new skills appropriate to the situation.

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WARNINGS

CARDIAC FAILURE In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn. b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker in one case this resulted after an initial dose of 5 mg propranolol

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levarterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY: Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block; hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura. *Central Nervous System*: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal*: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic*: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory*: bronchospasm. *Hematologic*: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous*: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings*: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

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Reference: 1. Freis, E.D. Hypertension (Suppl. II) 3:230 (Nov.-Dec.) 1981

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CASE REPORT

Pediatric Team Approach to Violent Early Bereavement

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In view of the substantial literature supporting the concept that early childhood bereavement produces long-term psychopathology, a pediatric service provided coordinated interventions with a 3½-year-old boy who had been shot and had witnessed the murder of both parents. The integration of medical, nursing, and psychological efforts is described.

Substantial psychiatric literature supports the concept that early childhood parental bereavement produces long-term psychopathology.[1-4] Retrospective studies of adolescents and adults who were bereaved in childhood indicate that a wide range of later psychopathology is associated with early object loss and its maladaptive resolution.[5,6]

Prompt, intensive, and continued psychological intervention with young victims of violence and loss has been urged strongly to counteract possible long-term deleterious effects.[1] This study reports a case in which medical, nursing, and psychological care were coordinated to serve a 3½-year-old boy who had been severely injured and had witnessed the gun slaying of both parents. Compounding the tragedy was the fact that the assailant was the patient's maternal uncle, who was out on pass from a county psychiatric hospital.

BACKGROUND AND DESCRIPTION

The patient was a 41-month-old male who was admitted to the emergency room of Newark Beth Israel Medical Center after sustaining a gunshot wound to his head. On arrival he was unresponsive, vital signs were absent, and pupils were dilated and nonreactive. Cardiopulmonary resuscitation was accomplished successfully; ventilation was assisted by a respirator and he was transferred to the intensive care unit.

Physical examination revealed deviation of his left eye medially; there was active bleeding from two wounds: one at the left parietal region just above the mastoid and the other at the tip of his nose just above the right nostril. Skull x-rays revealed destruction of left-sided facial bones but no apparent penetration into the calvarium.

Four hours after admission, he developed generalized seizures which responded to anticonvulsive therapy. Twenty-four hours after admission, he became responsive to pain and shortly thereafter to verbal command. On the third hospital day, he regained consciousness, was weaned from the respirator, and was started on oral feedings. At this time a left peripheral facial nerve palsy was obvious.

On the sixth hospital day, passive physiotherapy was begun, and on day seven he began active ambulation.

PURPOSES OF INTERVENTION

Pruett emphasizes the necessity for helping professionals to move swiftly in instances of massive object loss since personality develops swiftly in young children and there is high pathogenic potential when maladaptive responses to stress become fixed.[1] The pediatric psychologist began an intensive series of consultations and training meetings with family and staff members. Similar content was covered for all participants, but communication was geared to the specific

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intellectual, educational background, and involvement of each adult. Work with family members took into consideration their own loss as well as the child's loss; work with pediatric house staff and nurses included specific reading materials[1,2,3] as well as daily review of the patient's verbal communications.

ISSUES IN CONSULTATION AND TRAINING

Since the patient suffered such an extreme and sudden deprivation in the continuity of his care, stress was placed on the importance of consistency of human contact. One nurse (whose name, coincidentally, was the same as that of the patient's mother) was assigned to be available to him. On each shift, one nurse was given primary responsibility. All agreed that once the patient's memory of the shooting returned, he would be told the truth promptly; euphemisms (i.e. "gone away" or "gone to sleep") that adults employ in well-intentioned efforts to comfort a child would be avoided.

The patient's level of psychosexual development, his cognitive and emotional resources, his prior relationship with each parent, and his current available supports were among the factors needing consideration. The salient surviving relatives were his maternal grandfather and a 23-year-old unmarried aunt who lived together in an apartment in the same building were the patient had resided with his parents. They had constant contact with the child before the tragedy and visited him daily during his hospitalization. The patient's maternal grandfather was awarded temporary custody and his aunt left her employment to devote herself to the care of the child.

"Prompt, intensive, and continued psychological intervention with young victims of violence and loss has been urged strongly to counteract possible long-term deleterious effects."

All of the adults were prepared to understand that the patient might not seem to be reacting "appropriately." The psychologist pointed out that children do not spontaneously go through the phases of "grief work" considered by Freud to be necessary in adult mourning and healing.[7] Authors differ about when and even if children can mourn. Furman maintained mourning can be observed from the fourth year onward;[4] Wolfenstein found mourning impossible until after adolescence,[9] and Kliman found that mourning can take place whenever it is facilitated by therapeutic intervention.[10] All agree that unresolved grief can be highly pathogenic.

Staff and family understood that the patient might seem to accept that his parents were dead without understanding the finality of the situation. The irreversibility of death generally is not understood by children under six or seven years old. Fantasies of reunion are common even in older children.[4,9,10]

Guilt is another common reaction for which we prepared. The normal egocentricity of preschool children often leads to self-blame for parental departure—seen as abandonment or punishment for bad behavior or even normally angry thoughts. The irrational guilt serves two other purposes; it protects a child from feeling totally helpless and it channels, by turning inward, the rage felt toward the parent(s) who abandoned him.

A plan for the patient's care and living arrangements was made while he was still in the hospital and was to be communicated to him promptly, clearly, and as consistently as possible.

A family complication occurred when the paternal grandparents and paternal aunts announced they would attempt to get permanent custody. Anger was caused by hints that the history of mental illness in the patient's maternal family might make the home unsuitable, as might its location in the same building where the shooting had occurred. A family conference was called by the psychologist to prevent a court battle and subsequent conflict for the child. Emphasis was placed on a consistent home environment with those the patient knew best, but agreement was reached that paternal relatives also would be part of the patient's life and that he would be encouraged to visit and maintain a relationship with them.

ISSUES IN DIRECT CHILD THERAPY

Once the patient responded to medical treatment and began to speak (about a week after admission), it was clear that he was an unusually bright child, that he had been close to and well loved by both parents, and that he remembered the shooting episode quite vividly. Playing with stuffed animals in the crib, he told the psychologist, "I love Snoopy, and I love my Ducky, but I hate Uncle Tom because he killed my Mommy and Daddy. He took his gun and it went bang, bang. They fell down. Then it banged me."

Many times in sessions in the weeks to come, he was to enact the killing and revival of play materials; animals and dolls. His fantasy of reversibility and of a happy ending were apparent; gradually they yielded (but not completely, for many months) to the acceptance of reality.

The patient expressed the guilt that is so commonly a concomitant of early loss.

"I hate myself, and my toes hate me too."

"Why should your toes hate you?" he was asked.

"Because I was a bad boy, so Mommy and Daddy got dead."

Over and over it was necessary to reiterate that death was something a little boy could not control. The patient was reassured that all children are sometimes angry at mothers and fathers, but that angry thoughts and feelings do not make people die.

The patient was able to mourn and the adults around him catalyzed the process. There were outbursts of tears and from time to time the excruciating question, "Why can't they never come back to me?" Like that of all children, the patient's "sadness span" was short and checked by efforts not to drown in unstoppable grief.

His grandfather and aunt were encouraged to share their own sadness with the child rather than to project denial and specious cheer. His grandfather was able to hold the patient and say through his own tears, "Your Mommy was my child and I loved her. You are her child and she loved you. A terrible thing has happened to us both, but we have one another." The sight of the big man and the tiny boy hugging and crying together is one we will not forget.

Even had the patient not suffered a double bereavement, his own bodily trauma, hospitalization, and treatment would have constituted severe stress for him. The almost constant presence of surviving family members was an invaluable support. Provisions were made for his aunt and grandfather to stay overnight on the pediatric floor when the patient first recovered consciousness; again two weeks later when he

manifested severe separation anxiety; and again five weeks after admission when he was prepared for surgery.

In his daily sessions with the psychologist, the patient played at destroying and mending, taking apart and putting together toys and play materials. There was fear expressed that when his intravenous treatment was discontinued something catastrophic would happen. The tube was seen as a source of strength that he was too weak to do without.

The child life coordinator provided a strong adjunct to therapy, playing out with the patient through special "doctor materials" every procedure the patient was expected to undergo—ahead of the event. Thus, the patient was able to turn a passive role into an active one and practice being the one who gave rather than received shots, who took x-rays, and who "cut into people." The "doctor play" also provided an avenue for venting normal hostile reactions to the doctors and nurses whose functions sometimes caused the patient pain. The child life coordinator scheduled trips to see the x-ray center and the operating room.

The patient became extremely curious about the other children, asking, "Who broke Patty's arm?" or "Why does Billy got no hair?" or most poignantly, "Do any kids die here?" It happened that there were no deaths on the unit during the patient's stay. Had such a tragedy occurred, it would have been handled without evasion and with opportunity for our patient to ventilate his own feelings and to understand in what way his own situation was different.

The child life coordinator was able to keep the psychologist informed about the patient's interactions with other children in the playroom and his expressions of fear, anger, guilt, and sadness that became issues in his ongoing therapy.

ADJUSTMENT IN HOSPITAL

When the patient was well enough to leave the intensive care unit (ICU), which had been home for over a month, he was taken on a tour of the general pediatrics floor and shown the room he would occupy. He was given special permission to continue to visit "his" ICU nurses and they to visit him. He was helped to relinquish the constant attention which had been his, and to accept (after some protest) normal pediatric routines like naptime. His aunt and grandfather were extremely cooperative in implementing discipline despite natural tendencies to indulge a child in these circumstances. They and the nursing staff reached clear, unambiguous agreement about what would and what would not be permitted and how limits would be set.

With each day, the patient was stronger physically and related openly and affectionately with his family and staff, seeming able to utilize nurture from a wide variety of sources. He became a great favorite with children of all ages and was thoroughly identified with hospital life. It was funny to see him interject his small, sturdy body between two quarreling teenagers and say, "Quit it, guys. We don't fight here."

After five weeks our patient was in adequate health and was prepared for surgery (attempted repair of facial nerve). He was taken to inspect the operating room and helped to play out with the child life coordinator and the psychologist the steps that would occur (using special miniature doctor figures and stretchers). Patiently and with seeming acquiescence, the patient put the doll on the stretcher, gave it a shot, trundled if off, and then said firmly, "No way!"

The morning of the operation, he was tense and angry, complaining bitterly about his hunger and talking rapidly about the shooting. His anxiety mobilized vivid memories that became confused with images of what was to transpire during the operation. He was reassured that he would not die and was, in fact, expected to tell us all about it when it was over. He was on the table for six hours. The next morning, bandaged and hooked to an intravenous tube, he was able to grin and say, "They shot me six times—I'll show you."

Two days after the patient's discharge, he came back to the hospital at his own request "to see if my nurses are okay." He had awakened crying, apprehensive that perhaps they, too, had died. His grandfather dressed him and brought him for a visit to the place that had been home during a crucial time of his life.

RESULTS OBTAINED

The patient continued to visit the hospital. His aunt brought him for outpatient therapy with the psychologist, usually followed by his own "rounds" of touching base with the pediatric staff. Today, the patient is an alert, sturdy, and responsive little boy, presenting no severe symptoms. Followup continued on a weekly basis and then more widely spaced so that he could consolidate his gains and deal with developmental issues as they arose.

The patient's communication has been most revealing. He has gone through what Anna Freud calls "identification with the aggressor"[1]—playing at shooting everyone in sight. He went through a period of denial that the intactness of his body was violated, attempting to separate himself from his parents' fate ("They were shot, but not me. Oh no, he couldn't hurt me!"). He experimented with calling his aunt "Mommie." This was sensitively and appropriately discouraged by her. She has received encouragement and support not only in her child-rearing efforts but in her social vocational goals. She came to realize that her nephew's well-being would not entail the entire sacrifice of her own youth.

Ten months after the tragedy, our patient entered prekindergarten and is thriving there and at home. His young aunt returned to work. She and the patient's grandfather arranged their work schedules so that each can spend time with the child.

"Since the patient suffered such an extreme and sudden deprivation of the continuity of his care, stress was placed on the importance of consistency of human contact."

TEAMWORK

Routinely, the Assistant Director of Pediatrics leads weekly "Ecology Rounds" when all children in house are discussed with residents and the support personnel (representing clinical nursing, social work, psychology, pharmacology, home nursing, and child life coordination). This is always an excellent time for teaching and learning about child development, psychopathology, family issues, and the impact of health care.

For our patient's unusually long and complicated stay in the hospital, additional special sessions were set up by the psychologist on an ad hoc basis to assure smooth coordination between medical, nursing, and psychosocial care. Everyone involved knew at any time what had taken place,

when next steps were planned or might occur. For example, nurses were alerted to possible reopening of conflict between the patient's visiting maternal and paternal relatives. The otolaryngologist who performed the microsurgery became part of the team before operating.

SUMMARY

Through a carefully orchestrated team effort, a 3½-year-old boy who suffered violent double bereavement and severe insult to bodily intactness appears to have escaped with few psychological scars. Prompt, intensive, and consistent interventions were employed to counteract maladaptive reactions to trauma and to diminish the likelihood of later psychopathology.

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Diaphragm Pacer for High Spinal Cord Injury

ARTHUR WINTER, M.D., ROBERT J. WEIERMAN, M.D.,
JOY LAING, C.N.R.N., Orange*

A high cervical lesion (C_1) is incompatible with life without assistance. An electrophrenic pacing stimulator (EPS) in a patient with this disorder permits the patient to be free of a respirator and allows restoration of speech.

Electrical stimulation was first performed 200 years ago by Christoph Hufeland in treating asphyxia neonatorum.[1] In 1948, Sarnoff introduced the phrase "electrophrenic respiration" to describe electrical stimulation of the phrenic nerve.[2] Since 1966, through the outstanding achievements of Glenn and his associates[3] and Avery Laboratories,[4] many of the difficulties of implantation technique have been eliminated.

An electrophrenic pacing stimulator (EPS) has been used for more than two years in a patient with a C_1 cervical lesion. A lesion this high is incompatible with life.

CASE REPORT

On July 1, 1979, a 60-year-old man was admitted to the emergency room of The Hospital Center at Orange with a history of being shot through the mouth and chest with a small-caliber (.25) pistol. The first bullet severed the spinal cord at C_1 and the second bullet entered the left lateral portion of the chest (Figure). He was resuscitated by the first aid squad, intubated in the emergency room, and placed on a mechanical respirator in the intensive care unit. On admission to the intensive care unit, he was placed on a Stryker frame.[5] The patient regained consciousness and communicated with his eyes. On July 8, 1979, a tracheotomy was performed to replace the endotracheal tube.

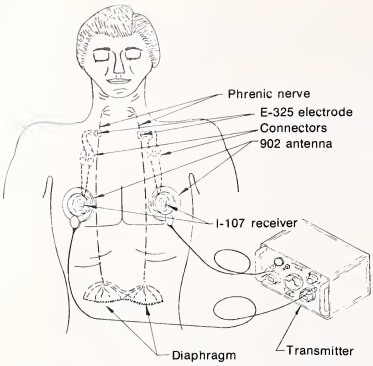
Two months later, the patient developed a bradycardia of 40 beats per minute, necessitating insertion of a "demand" pacemaker on September 4, 1979. After five months on mechanical ventilation, with the patient maintaining a stable condition, the decision was made to implant a diaphragm pacemaker (EPS). The electrophrenic stimulator (EPS) implant was performed on the left diaphragm on November 27, 1979, and on the right diaphragm on December 5, 1979. The equipment for diaphragm pacing consists of an external, battery-powered radiofrequency transmitter and antenna, subcutaneous radio receiver, and bipolar platinum nerve electrode. The purpose was to free the patient from a ventilator and to restore speech. He was able to communicate only with his eyes prior to surgery. The time of phrenic stimulation was increased gradually because of nerve fatigue from ten minutes per hour for 6 hours on the first day to 12 hours continuously by the seventh day.[6]

DISCUSSION AND METHODOLOGY

Speech therapy was begun at approximately eight weeks postoperatively. The tracheotomy tube was corked for increasingly longer periods of time beginning with 30 minutes.

A Roto Kinetic Bed was obtained to avoid the complete rotation necessary with a Stryker bed.[7] The patient's attitude

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Figure—Diaphragm pacer with bilateral insertion onto phrenic nerves.

improved considerably with the change. As he no longer was required to be placed in the prone position, pacing did not have to be interrupted and he began asking about the possibility of getting into a wheelchair.

It is now over 24 months since the patient had his bilateral implantation of the electrophrenic stimulator (EPS). He is being paced continuously and he tolerates being in a wheelchair for up to four hours each day. His tracheotomy tube is corked when he wants to speak. His speech has improved greatly so that he is able to communicate his needs, which promotes better medical care.

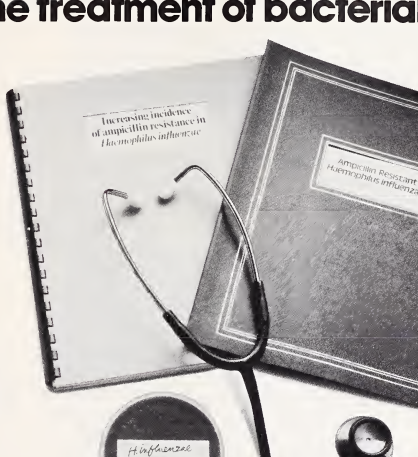
SUMMARY

A reliable system of diaphragmatic pacing, even at a C_1 level, can be performed in a full-service community hospital. The electrophrenic pacing stimulator (EPS) permits the patient to talk, allows independence from a respiratory device, and provides a method of sustaining normal respiration physiology.

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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-5]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[2]

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Brief Summary. Consult the package literature for prescribing information

Indications and Usage. Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae, and S. pyogenes (group A beta-hemolytic streptococci). Appropriate bacteriological studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication. Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings. IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUGS.

ADSEL

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuation alone. In moderate to severe cases, consideration should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions. General Precautions. If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the donor cell or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions careful clinical observation and laboratory studies should be made because dosage may have to be reduced in accordance with creatinine clearance.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in fertile given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.29, 0.23, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions. Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and consist chiefly of nausea.

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Rarely, erythema multiforme, anaphylaxis, toxic epidermal necrolysis, and Stevens-Johnson syndrome accompanied by arthritis/arthralgia and, frequently, fever have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No sensitivity sequelae have been reported. Antihistamines and corticosteroids may be beneficial adjuncts in the management.

Cases of anaphylaxis have been reported, but of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Clinical Laboratory Directions—Transitory abnormalities in clinical laboratory tests have rarely been observed. Although they were of uncertain etiology, they are listed below to serve as a ready information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

10061BEN

*Many authorities attribute acute infectious exacerbations of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prophylaxis of streptococcal infections, excluding the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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Prevention of Impairment

DAVID I. CANAVAN, M.D., Lawrenceville*

The present-day physician is a product of an educational process that continually has been modified and refined in the attempt to provide an intimate exposure in an atmosphere conducive to ready absorption and understanding of a constantly accelerating supply of essential medical information. The sheer volume of basic medical knowledge produces an ever-increasing burden on administration, faculty, and students simply to keep abreast of the times. This mounting pressure begins in the premedical years and is sustained through the residency program and into the years of active medical practice.

The ability to accumulate and assimilate this vast storehouse of scientific and medical facts requires a high degree of intelligence and a rigidly disciplined personality. The time alone that may be required demands major sacrifices in other areas of life. Moreover, in the undergraduate years, the added stress of stiff competition for a limited number of medical school places, creates another set of pressures in the life of the aspiring student.

This same issue, limited access to medical school, has created problems for admissions committees in attempting to establish appropriate guidelines for acceptance. Faced with a large volume of applications from academically excellent students, admission committees have tended to use yardsticks of academic performance to select candidates for admission to their freshman class. Repeated experience has shown that this is not the best criterion. It is extremely difficult, however, to establish reliable guidelines or testing procedures to identify prerequisites of the competent, capable, compassionate, and stable human beings who consistently will be the best physicians.

A further problem in the selection process involves "the other side of the equation," i.e. the selection of medicine as a potential career by the students. While it probably is safe to say that the majority of candidates are stable, well-adjusted human beings, a significant number seek a medical career to bolster their own feelings of inadequancy and low self-esteem.

Dr. Abraham Twerski, a leading authority in the field of physician impairment, in addressing this issue states: "The individual who is socially fluent, is interpersonally warm, and has needs for abundant human contact may find it quite intolerable to isolate himself for the long periods of time necessary to memorize and digest the enormous number of facts required to get into and through medical school. Furthermore, the individual who is person-oriented may be so repulsed by considering the human as primarily a physiological-chemical system, that he cannot adapt to a medical career. The very process of selection thus tends to favor doctors who can be interpersonally detached and who can exist in relative social isolation."[1]

Several factors in the medical school environment encourage the development and exaggeration of traits that later may become debilitating. For example, there is a tendency toward: development of an excessive workload; self-denial; repression of feelings; neglect of personal needs; and intellectualization of emotions.[2,4]

During the residency years, the same factors continue to operate but there now are additional stresses imposed. These include: unrealistic call schedules; excessive patient loads; financial worries; concern over personal and professional identity; alienation from the mainstream of society; scarcity of leisure time; and dissatisfaction with spouse and family relationships.

Certain physical risks are added to the life of the resident: major infection hazards (hepatitis, TB, viral diseases); exposure to toxic gases and chemicals; self deprivation; lack of regular exercise; and poor nutritional habits.[3]

Is it any wonder that this system leads to problems in its participants? While those who start out with a poor self-esteem and feelings of personal inadequacy may be at greatest risk, all residents are exposed to these stresses and can be vulnerable to their damaging effects.

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Prevention of impairment during these important years in the training and development of the physician readily can be divided into two separate phases.

Primary Prevention is aimed at avoiding impairment. This requires an active commitment on the part of the medical schools and the residency training programs to the elimination of unnecessary sources of stress and the adequate provision of time and effort to assist the students and residents in developing the skills that are necessary to cope with the challenges and stresses of their educational years as well as preparing them for the years beyond in active practice.

"This mounting pressure begins in the premedical years and is sustained through the residency program and into the years of active medical practice."

The first step must be to make it absolutely clear that it is a normal acceptable human characteristic to experience stress and that such a feeling does not imply weakness, inadequacy, or lack of competence.[5]

Students and residents must learn to develop a realistic appreciation of medicine as a satisfying career, "a jealous mistress," and a potential obsession. It is essential that a proper balance be established between their equally important and sometimes conflicting needs as physician and person. Someone has wisely said we do not deal with impaired physicians but rather we deal with impaired persons who happen to be physicians. This impairment often is due to neglect of the personal elements in the physician's life by teacher and student as well. Many routes are available to reach the goal of prevention.

Orientation sessions, periodically spaced throughout the educational process, to reestablish appropriate priorities, to anticipate and prepare for expected stresses, and to develop the skills to deal with the unexpected are very helpful.

Support groups designed to match peers with similar backgrounds and lifestyles can provide an effective vehicle for sharing problems and solutions of mutual concern.

Faculty role models with whom the student comfortably can relate for guidance in both educational and personal matters during the developmental years go a long way in "smoothing these troubled waters."

Retreats have been successfully used by many programs. Taking the residents away from the workplace to more relaxed surroundings to address and work out conflicts, stresses, personal problems, and personal needs is very effective in aiding these residents in developing coping skills.

The needs of the student and the resident for appropriate leisure activities, adequate exercise, spiritual development, proper nutrition, and adequate rest all must be addressed if your program is to succeed.

Secondary Prevention involves the appropriate management of students or residents who have developed impairment as a consequence of heredity, personality defects, the stresses of their training, and/or the inappropriate use of mood-altering chemicals (alcohol and/or drugs) as recreational pharmacology or to escape from dealing appropriately with their lives and the stresses they confront. Identification, treatment, and rehabilitation at this stage can salvage a life and a career that is headed for disaster. Medical schools and training programs have a real obligation to recognize the potential for and the actual existence of impairment in students and residents.

A well-defined policy should be established for dealing with impairment when it occurs.

Ideally, a nonthreatening, therapeutic approach should be taken. A senior, stable, and respected faculty member should be identified to deal with these problems; his availability should be made known to the students or residents and the rest of the staff.

Problems should be handled in confidence unless the welfare of the institution or its patients is threatened seriously.

Patterns of referral should be established in advance, and provision should be made for financial assistance as necessary so that when a problem does arise it can be handled promptly, efficiently, and with as little fanfare as possible.

The involved student or resident should be treated as a patient and offered the therapeutic opportunities available to any other patient. They must be granted the opportunity to complete the therapeutic process with the expectation of being accepted back into the program if they are successful. Denying them readmission under those circumstances is a denial of the therapeutic system and is a contradiction of what medicine is all about.

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Trustees' Minutes December 19, 1982

A regular meeting of the Board of Trustees was held on Sunday, December 19, 1982, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Memorial Resolution . . . Observed a moment of silence in tribute to the memory of E. Vernon Davis, M.D., who died on December 12, 1982. Received unanimously the following memorial resolution:

Whereas, the Almighty has chosen to call from us His loyal servant, E. Vernon Davis, M.D.; and
Whereas, as an Officer and Fellow of the Medical Society of New Jersey, Doctor Davis served the members of this Society and the people of New Jersey; and
Whereas, by his example he demonstrated the attributes of a humanitarian and concerned practitioner; now therefore be it
Resolved, that the Medical Society of New Jersey expresses its sorrow at the death of E. Vernon Davis, M.D., and extends its sympathy to his beloved family; and be it further
Resolved, that this Resolution be spread upon the minutes of this meeting and a copy, suitably prepared, be presented to his bereaved family in heartfelt sympathy.

Report of the President . . .
(1) AMA Advisory Committee on the Health Policy Agenda for the American People . . . Approved unanimously the nomination of Alfred A. Alessi, M.D., for appointment as MSNJ's representative on one of the work groups of the Advisory Committee on the Health Policy Agenda.
(2) Statewide Peer Review Mechanism . . .Noted that MSNJ proposes a leadership role in the development of a peer review system.

Joint Commission on Accreditation of Hospitals . . . Received the report by James S. Todd, M.D., as informative with the understanding that those opposing the proposed revisions to the medical staff section of the *Manual for Hospitals* can submit their statements to the Executive Director in writing for inclusion in the Society's reponse to the JCAH. Noted that drafts were being sent to state medical societies, hospital associations, and individual hospitals for review.

New Jersey State Medical Underwriters, Inc. . . . Approved that the bylaws of the Underwriter be amended to reflect that the number of members of the Board of Directors of the corporation shall be eight, and shall include the President of MSNJ or his designee, the Executive Director of MSNJ, and the President of the New Jersey Association of Osteopathic Physicians and Surgeons or his designee with no change occurring in the bylaw language pertaining to appointed seats. Approved the appointment of Palma E. Formica, M.D., to serve a three-year term on the Board of Directors. Approved the preparation of an agreement between MSNJ and the New Jersey Association of Osteopathic Physicians and Surgeons to assure an osteopathic member a seat on the Board of Directors of the New Jersey Medical Underwriters, Inc., as long as osteopaths are insured by the company. And, noted that authority to execute the necessary consents and documents was given to the President and the Executive Director.

AMA Delegation . . . Noted the information presented by Doctor D'Elia in a brief report on the actions taken by the AMA House of Delegates at its Interim Meeting: a) approved a statement opposing provisions of the new Tax Equity and Fiscal Responsibility Act affecting reimbursement of physicians; b) established a new AMA Section on Hospital Medical Staffs to provide a national forum for addressing urgent issues facing medical staff physicians; c) agreed to maintain the current system of specialty society representation and declined other changes in the composition of the AMA House of Delegates; d) voted to invite the American Hospital Association and American Dental Association to send official observers to AMA meetings; e) rejected plans to grant one additional AMA delegate to each state when 75 percent of its members belong to the AMA, and to provide extra seats to specialty societies when 75 percent of their members also are AMA members; f) directed the AMA to forward timely reports of the Health Policy Agenda Steering Committee to all state medical societies, AMA delegates, and alternates for review and input, so that practicing physicians can have a stronger role in the development of the Health Policy Agenda; g) discussed consumer choice principles; h) approved standards for state medical societies to follow in accrediting local institutions and organizations that offer continuing medical education (CME) courses in their states; and; i) will continue to study the expanding body of knowledge related to civil defense preparedness and proposed crisis relocation and shelter plans, and inform the public and the profession of the medical consequences of nuclear war.

Report of the Executive Director . . .
(1) MSNJ 1982 Paid Membership . . . Noted that November 30, 1982, statistics indicated that MSNJ is 58 paid members short of the December 31, 1981, figure.
(2) County Comparison 1982 to 1981 Paid Memberships . . . Noted that a serious deterioration in membership exists in several county societies including Cumberland, Essex, Mercer, and Monmouth.
(3) Ad Hoc Committee on Presentation of MSNJ's DRG Position . . . Approved the following recommendation:

That the Board of Trustees authorize the establishment of an Ad Hoc Committee on Presentation of Medical Society of New Jersey's DRG Position. The members of the committee will be appointed by the President.

(4) Ad Hoc Committee on Women Membership . . . Approved the following recommendation noting that the decrease in membership is a matter of real concern to MSNJ and that women physicians are becoming the largest, increasingly identifiable source of medical talent:

That the Board of Trustees authorize the establishment of an Ad Hoc Committee on Women Membership. The members of the Committee will be appointed by the President.

(5) Seminar on Hospital Corporate Structures and the Impact on the Private Practice of Medicine: Approved the following recommendation:

That the Board of Trustees authorize staff to present a seminar on Hospital Corporate

Structures and the Impact on the Private Practice of Medicine at the Executive Offices during the spring of 1983.

(6) **Legal Matters . . .**

(a) **Subordinated Loan Deductibility** . . . Noted that this matter is in litigation before the United States Tax Court; the court has decided to appoint a special trial judge to hear the issue and a motion will be made before the judge in March.

(b) **State Board of Medical Examiners vs. Greco** . . . Directed that the following course of action be taken: 1) that the Society intervene before the State Board of Medical Examiners and request an amicus curiae appearance before that body; 2) that a request be made of the State Board of Medical Examiners to allow Doctor David Eckstein to testify before the Board on behalf of the Society and the membership; 3) that a policy statement be drafted incorporating the above comments; and 4) that the topic of "death with dignity" in long-term care facilities be referred to the Committee on Biomedical Ethics for discussion.

(7) **Legislative Matters . . .**

(a) **A-2057—Expansion of Physical Therapy Practice** . . . Opposed vigorously this bill that would license physical therapists as independent health practitioners who, without any medical evaluation, could receive, diagnose, and treat patients.

(b) **A-954—Hypnosis** . . . Opposed this bill that would license the independent practice of hypnosis.

(c) **A-991—Audiologists and Speech Pathology** . . . Opposed aggressively this bill that creates and licenses the practice of audiology and speech pathology through the Division of Consumer Affairs.

(d) **A-2149—Optometry** . . . Opposed this bill that permits optometrists to use topical anesthetics and medications.

(e) **S-1813—Permits Nurses To Complete Death Certificates** . . . Opposed this bill that would allow a registered professional nurse to make the actual determination and pronouncement of death and attest to the fact of this pronouncement in a designated space on the certificate of death form; officially execute the certificate of death; and receive a reasonable fee for the performance of these services.

(f) **S-762—Acupuncture** . . . Opposed actively this bill that would establish acupuncture as a free-standing health care profession; attempting to have the Governor veto this bill.

(g) **A-784 and A-785—Reporting of Disciplinary Proceedings and Malpractice Actions** . . . Agreed to continue the present position on these bills (active opposition to **A-784** and no action on **A-785**).

(h) **A-721—Administrative Law** . . . Supports actively this bill that provides that sole decisional authority in contested matters of administrative law is vested in the administrative law judge.

(8) **Medical Student Loan Defaults** . . . Will refer physicians who have a relationship to MSNJ and are in default of MSNJ loans to the appropriate county judicial committees for action.

Medical Society of New Jersey Student Association . . .

AMA Leadership Conference . . . Approved the following recommendation:

That the Medical Society of New Jersey fund two students (one from Rutgers Medical School and one from New Jersey Medical School) to attend the AMA Leadership Conference each year. (The 1983 Conference will be held February 17 to 19 in Chicago.)

Council on Public Health . . . Suggested the following recommendation:

That the film, "The Last Epidemic," available through the Physicians for Social Responsibility be shown to the members of the House of Delegates at the 1983 Annual Meeting.

Council on Mental Health . . .

Appointment of a Limited Guardian for Certain Persons Exposed to Coercive Persuasion . . . Approved the following recommendation:

That the Board of Trustees disapprove **S-488** and **A-1087** mainly on the basis that the potential for the abridgement of civil rights outweighs any potential gains made by the appointment of a guardian for those enmeshed in any of these movements. Certainly psychiatrists are opposed actively to any of these sects since they not only entrap youths but are prone to use medicine and psychiatry as targets of their abuse, i.e., scientology.

Committee on Medical Education . . .

Request To Investigate Future Physician Supply in New Jersey . . . Received as informative the report of the Committee. Noted that in response to Resolution #1, MSNJ staff has been trying to investigate the future physician supply and future requirements in New Jersey in the following ways: 1) memos were mailed to each county medical society requesting need for physician coverage in their county; and 2) requests were made to the Advisory Council on Graduate Medical Education and to the Department of Higher Education for statistics. Noted that the Committee felt it did not have the resources available to conduct a meaningful survey on the subject.

Committee on Medicaid . . .

Restriction of Out-of-State Referrals by New Jersey Medical Assistance Program . . . Received as informative the statement from the Committee in reference to a resolution from Cumberland County. Noted by Dr. Yuliano, Medical Director of the Division of Medical Assistance and Health Services, that Medicaid does reimburse out-of-state physicians for medical services to New Jersey residents who are covered by the program and the regulation provides for reimbursement for out-of-state hospitals with prior authorization.

Committee on Publication . . .

Program To Publish a Periodical for Members of Hospital Governing Boards . . . Received as informative from the Committee on Publication that Resolution #9 has been complied with; starting in December, 1982, in *The Journal* is a column entitled "Hospital Governing Boards." This column will appear in all future issues.

Committee on Impaired Physicians . . .

Board of Directors . . . Approved the following recommendation:

1. That the Board of Trustees of MSNJ approve the establishment of a Board of Directors of the Impaired Physicians Program *to monitor the fiscal affairs of the program.* (*Italics* indicate amendment by the Board.) 2. That each funding source be responsible for the appointment of its representative(s). 3. That MSNJ's representatives be appointed for a term of three years.

Noted members of the Board of Directors are: Palma E. Formica, M.D., Paul J. Hirsch, M.D., Peter Sweetland, William J. Reilly, Donald Smith, Richard Jones, David I. Canavan, M.D., and a representative from the New Jersey Association of Osteopathic Physicians and Surgeons.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

In the early months of a new year I generally reserve this space to recap some of the major events at the University that occurred in the preceding year, our first as a university. That column will have to wait, however, in view of the more pressing nature of some of the events that transpired recently.

As a major investment in our future, UMDNJ has entered into a contract with the Hospital Corporation of America (HCA) to manage University Hospital, Newark, for the next three years. The agreement was authorized by our Board of Trustees in early December following a lengthy study to determine the most efficient and effective means of operating the hospital.

Under the agreement, HCA will manage all aspects of the 530-bed hospital including services previously supplied by our central administration. After very careful study, we are confident that HCA—which is responsible for more than 360 hospitals world-wide and is one of the outstanding organizations of its kind—will provide the direction University Hospital requires at this point in its development.

As you know, University Hospital, the only acute care hospital actually owned by the state, has the dual responsibility as the primary source of comprehensive care to a large segment of Newark's population as well as being a center of sophisticated medical specialty services and a primary teaching hospital for the state. Obviously, we have great expectations for this beautiful facility and we believe that with the assistance of an organization with the expertise of HCA, University Hospital will achieve the preeminence and recognition it aspires to on state and national levels.

While negotiations were underway to finalize the contract with the hospital management organization, a significant medical story broke with major focus on our Newark campus. The story dealt with the first cases of acquired immunodeficiency syndrome (AIDS) identified in children and the man in the spotlight was Dr. James Oleske, division director of allergy, immunology, and infectious disease, UMDNJ-New Jersey Medical School.

At a press conference, in conjunction with the New Jersey State Department of Health, Dr. Oleske told a packed room of television and newspaper reporters of eight New Jersey cases—four of which had already resulted in death—of AIDS discovered in New Jersey children.

All of the children came from households in which at least one parent or guardian was a homosexual, intravenous drug user, Haitian, or hemophiliac, groups which heretofore were the only victims of the condition.

The children's cases have been confirmed by the New Jersey Department of Health and the Atlanta-based Centers for Disease Control, which has been investigating the outbreak and spread of AIDS for nearly two years.

Dr. Oleske said he and other researchers initially were looking to sperm in the rectum, or drugs, as the source for the immunological breakdowns. However, he said, investigators are now focusing on an infectious, transmissable agent that can be acquired without homosexual relations or drug use. Dr. Oleske emphasized that none of the children suffering from AIDS were abused in any way.

Two of our core teaching hospitals recently have changed their names to reflect their relationship with the University. Middlesex General Hospital, New Brunswick, core teaching hospital for UMDNJ-Rutgers Medical School, is now Middlesex General-University Hospital. In South Jersey, Cooper Medical Center, core hospital for UMDNJ-Rutgers Medical School, Camden, formally changed its nomenclature to Cooper Hospital/University Medical Center.

In the coming months we plan to bring you articles dealing with the emergence and development of UMDNJ's core teaching hospitals and how they are contributing to the advancement of medical education and health care in New Jersey.

MSNJ Auxiliary

Linda J. Hirsch
President

Auxiliary members, spouses, and friends are invited to attend the second annual legislation trip to Washington, D.C., April 13-14, 1983, sponsored by the Medical Society of New Jersey Auxiliary. Participants will stay at the Hyatt Regency, located a block from the Capitol.

Trip itinerary includes a tour of the Vincent T. Lombardi Cancer Research Center, Georgetown University Medical Center; shopping in Georgetown; and tour of the White House. During dinner at the Hyatt, Ms. Carla Neuschel, AMA lobbyist, will present a legislative briefing. Each auxiliary member will visit her congressman, having made an appointment prior to the trip. Lunch and tour of the AMA building will complete the trip.

Reservations must be made by mid-February, 1983, by forwarding your $25.00 deposit to: Angelina Campo, 1028 Lawrence Road, Lawrenceville, NJ, 08648 (checks payable to Angelina Campo). Balance of $100.00 due by March 1. Buses will depart from north and south Jersey locations. For further information, contact the MSNJ Auxiliary Office in Lawrenceville, (609) 896-1766.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Bert Guajardo, M.D., 7907 Belle Park Dr., Houston, TX 77072. Creighton 1979. Board eligible. Group or partnership. Available.

FAMILY MEDICINE—Daniel J. Sastic, M.D., 9 Farragut Drive, Piscataway, NJ 08854. Rochester 1980. Board eligible. Group or partnership. Available June 1983.

David Kaufman, M.D., 70 Lancaster Rd., West Hartford, CT 06119. St. Louis 1975. Board certified. Partnership or group. Available July 1983.

Max Burger, M.D., 11 West 69th St., New York, NY 10023. Royal College of Surgeons (Ireland) 1976. Board certified. Group, HMO, partnership. Available.

GASTROENTEROLOGY—William W. Mark, Jr., M.D., 2289 South Lewiston St., Aurora, CO 80013. Guadalajara (Mexico) 1975. Also, general internal medicine. Group or partnership. Available June 1983.

Leonard Luterman, M.D., 5740 Cavendish Blvd., Apt. 1308, Montreal, Quebec, Canada H4W 2T8. McGill 1977. Also, general internal medicine. Board eligible. Any type practice. Available July 1983.

Louis D. May, M.D., 2122 Kensington Ave., Salt Lake City, UT 84108. Miami 1978. Also, general internal medicine. Board certified (IM). Group or partnership. Available June 1983.

Satya V. Jayanty, M.D., 131 Breckinridge Square, Louisville, KY 40220. Andhra (India) 1974. Also, general internal medicine. Board certified (IM). Partnership. Available July 1983.

GENERAL PRACTICE—Alan D. Brownfield Palo, M.D., 6611 Pelham Dr., Parma, OH 44129. Guadalajara (Mexico) 1976. Special interest in ENT. Office-based general ENT, surgical ER, surgical house staff. Available.

Jayen C. Shah, M.D., 4848 North Kimball, Apt. 2-N, Chicago, IL 60625. Baroda (India) 1974. Also, emergency room medicine. Group, partnership, solo. Available.

Mustafa Boyer, M.D., 168 S. Kentucky

Ave., Atlantic City, NJ 08401. Istanbul (Turkey) 1943. Partnership, nursing home, hospital house physician. Available.

INTERNAL MEDICINE—William W. Mark, Jr., M.D., 2289 South Lewiston St., Aurora, CO 80013. Guadalajara (Mexico) 1975. Subspecialty, gastroenterology. Group or partnership. Available June 1983.

Laurence N. Sechter, M.D., 1870 Stewart Ave., New Hyde Park, NY 11040. Rome (Italy) 1977. Subspecialty, nephrology. Board eligible. Partnership, solo, group. Available July 1983.

Young J. Ko, M.D., 2927 Dorchester St., Apt. 206, Troy, MI 48084. Chonnam (Korea) 1973. Subspecialty, pulmonary medicine. Board certified (IM); board eligible (PM). Solo, group, partnership. Available July 1983.

Frank Lopez, M.D., 60 Overlook Rd., Summit, NJ 07901. Einstein 1980. Board eligible. Group or partnership. Available.

Louis D. May, M.D., 2122 Kensington Ave., Salt Lake City, UT 84108. Miami 1978. Subspecialty, gastroenterology. Board certified. Group or partnership. Available June 1983.

Leonard Luterman, M.D., 5740 Cavendish Blvd., Apt. 1308, Montreal, Quebec, Canada H4W 2T8. McGill 1977. Subspecialty, gastroenterology. Board eligible. Any type practice. Available July 1983.

M. Zaslow, M.D., 24 Westgate Road, Chestnut Hill, MA 02167. Harvard 1977. Subspecialty, pulmonary medicine. Board certified (IM); board eligible (PM). Any type practice. Available.

David George, M.D., 76 St. Paul Street, Apt. 6, Brookline, MA 02146. Harvard 1978. Subspecialty, rheumatology. Board certified. Group. Available July 1983.

Arthur C. Tutela, M.D., 132 Midland Place, Newark, NJ 07106. Bologna (Italy) 1974. Also, general medicine. Group, partnership, clinic, institution. Available.

Andrew Stolzar, M.D., 3 Petunia Drive, Apt. 2-C, North Brunswick, NJ 08902. Graz (Austria) 1979. Board eligible. Group or partnership. Available July 1983.

Richard M. Moccia, M.D., 10 Loden Lane, Rochester, NY 14620. Dartmouth 1977. Also, gastroenterology. Board certified (IM); board eligible (gastroenterology). Solo, group, partnership, hospital-based practice combining IM and consultative GI. Available June 1983.

Dennis Parenti, M.D., 131-F Marina Drive, Edison, NJ 08817. Washington University 1978. Subspecialty, rheumatology. Board certified (IM); board eligible (rheumatology). Partnership or group. Available July 1983.

Robert M. Lintz, M.D., 80 High St., Apt. 21-B, Dedham, MA. Jefferson 1978. Subspecialty, gastroenterology. Board certified. Group, partnership, solo. Available.

Stewart A. Robbins, M.D., 73-11 210th Street, Apt. 2-K, Bayside, NY 11364. SUNY-Downstate 1978. Subspecialty, gastroenterology. Board certified. Group, partnership. Available July 1983.

Mel Kaplan, M.D., 48 Medinah Drive, Reading, PA 19607. New York University 1976. Board certified. Any type practice. Available.

Viswanath P. Vasudevan, M.D., 59-21 Calloway St., Apt. 5-L, Corona, NY 11368. Bombay (India) 1976. Subspecialty, pulmonary medicine. Board certified. Group or solo. Available July 1983.

Khalid I. Khan, M.D., 3317 Old Church Rd., Augusta, GA 30907. Khyber (Pakistan) 1975. Subspecialty, pulmonary medicine. Board eligible. Group or partnership. Available July 1983.

NEPHROLOGY—Carl S. Goldstein, M.D., 860 Gates Pavilion, 3400 Spruce St., Philadelphia, PA 19104. Washington University 1978. Also, general internal medicine. Board certified (IM). Group or partnership. Available July 1983.

OBSTETRICS/GYNECOLOGY—Francine A. Guzman, M.D., 132-17 58th Road, Flushing, NY 11355. New York Medical 1979. Board eligible. Group or partnership. Available June 1983.

Ho Young Kim, M.D., 1945 Corlies Avenue, Neptune, NJ 07753. Chonnam (Korea) 1972. Board eligible. Solo, group, partnership. Available July 1983.

OPHTHALMOLOGY—Michael Hostovsky, M.D., 4100 West 36th St., Minneapolis, MN 55416. Hadassah (Israel) 1972. Also, neuro-ophthalmology. Board eligible. Single or multispecialty group. Available.

Jasvinder Singh, M.D., 500 Central Ave., Apt. 702, Union City, NJ 07087. Lady Hardinge (India) 1970. Board eligible. Partnership, group, HMO. Available.

OTOLARYNGOLOGY—Richard Schiffman, M.D., 2717 East 28th St., Brooklyn, NY 11235. Tufts 1977. Board eligible. Partnership or group. Available.

Kwang H. Choi, M.D., 8704 Pellington Place, Apt. 3, Richmond, VA 23229. Seoul (Korea) 1976. Board eligible. Partnership or associates. Available July 1983.

Bruce Grossman, M.D., 215 East Chicago Ave., Apt. 1101, Chicago, IL 60611. Illinois 1978. Board eligible. Group or partnership. Available July 1983.

PATHOLOGY—Siamak Shokri-Tabibzadeh, M.D., Montefiore Hospital and Medical Center, 111 E. 210th St., Bronx, NY 10467. Tehran (Iran) 1977. Academic institution. Available.

Marvin N. Solomon, M.D., 3 Sutliff Ave., Vineland, NJ 08360. Berne (Switzerland) 1937. Special interest in anatomic and forensic. Board certified (PA); board eligible (forensic). Hospital staff, locum tenens. Available.

Pushpa Gupta, M.D., 100-C Thorndale Dr., Dayton, OH 45429. Dr. S.N. Medical College (India) 1971. Any type practice. Available.

PEDIATRICS—Shailesh J. Shah, M.D., 430 E. 67th St., Apt. 5-C, New York, NY 10021. Baroda (India) 1974. Board eligible. Special interest in pediatric hematology/oncology. Group, partnership, institutional. Available July 1983.

Renuka D. Desai, M.D., 1258 Liberty Bell Dr., Cherry Hill, NJ 08003. GS Medical College (India) 1973. Board certified. Group or partnership. Available.

Ann M. Hawryluk, M.D., 1804 Windsor Ridge Dr., Westborough, MA 01581. Harvard 1980. Board eligible. Group, partnership, HMO, solo. Available July 1983.

Edgar C. Orate, M.D., 1945 Corlies Ave., Neptune, NJ 07753. University of the East (Philippines) 1978. Board eligible. Group, partnership, solo. Available July 1983.

Alan M. Muney, M.D., 2353 Moreno Drive, Los Angeles, CA 90039. Brown 1978. Board eligible. Group or partnership. Available.

Are You Moving?

If so, please send change of address to *The Journal*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Name _____

Address _____

City _____ **State** _____ **Zip** _____

County _____

Attach mailing label from *The Journal*.

PSYCHIATRY—Paul L. Maitheny, M.D., 99 Pawnee Rd., Lakewood, NJ 08701. University of Graz (Austria) 1951. Board eligible. Available.

PULMONARY DISEASES—Young J. Ko, M.D., 2927 Dorchester St., Apt. 206, Troy, MI 48084. Chonnam (Korea) 1973. Also, general internal medicine. Board certified (IM); board eligible (PM). Solo, group, partnership. Available July 1983.

M. Zaslow, M.D., 24 Westgate Road, Chestnut Hill, MA 02167. Harvard 1977. Also, general internal medicine. Board certified (IM); board eligible (PM). Any type practice. Available.

RADIOLOGY (DIAGNOSTIC)—Kailash Tarneja, M.D., 8710-A Park Crestwood Drive, Crestwood, MO 63126. Delhi (India) 1974. Board eligible. Group, partnership, solo. Available.

RHEUMATOLOGY—David George, M.D., 76 St. Paul St., Apt. 6, Brookline, MA 02146. Harvard 1978. Also, general internal medicine. Board certified (IM). Group. Available July 1983.

SURGERY, GENERAL—Mohammad Amawi, M.D., 1904 Barham St., Dodge City, KS 67801. Damascus (Syria) 1971. Board certified. Group, partnership, multispecialty group. Available.

Larry E. Shindelman, M.D., 201 W. 89th St., New York, NY 10024. SUNY-Downstate 1977. Also, vascular surgery. Board eligible. Group or partnership. Available July 1983.

James P. Gadzik, M.D., 414 Country Lane, Narberth, PA 19072. Pennsylvania 1976. Group, partnership, general surgery (with vascular and thoracic). Available July 1983.

SURGERY, ORTHOPEDIC—Mark S. Berkowitz, M.D., 1045-55th St., Brooklyn, NY 11219. New York Medical 1978. Board eligible. Group or partnership. Available July 1983.

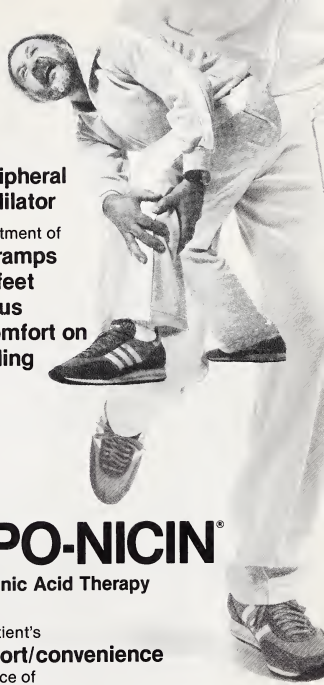
Shearwood J. McClelland, M.D., 380 E. Town St., Columbus, OH 43215. Columbia 1974. Board certified. Partnership or group. Available.

SURGERY, THORACIC—John P. Hubert, Jr., M.D., 33 Viking Village, N.W., Rochester, MN 55901. Minnesota 1975. Board certified. Private practice, single specialty in small group. Available July 1983.

SURGERY, VASCULAR—Larry E. Shindelman, M.D., 201 W. 89th St., New York, NY 10024. SUNY-Downstate 1977. Also, general surgery. Board eligible. Group or partnership. Available.

John P. Hubert, Jr., M.D., 33 Viking Village, N.W., Rochester, MN 55901. Minnesota 1975. Board certified. Private practice, single specialty in small group. Available July 1983.

UROLOGY—Howard L. Frey, M.D., 10982 Roebling Ave., Apt. 425, Los Angeles, CA 90024. Johns Hopkins 1977. Subspecialty, infertility and microsurgery. Board eligible. Group, partnership, solo. Available July 1983.



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Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

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Niacinamide .....75 mg.
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REFER TO PDR

Housing Application

217th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY
April 29-May 2, 1983

	Single	Twin	Daily Rates
Resorts International (headquarters hotel)	$75.50	$75.50	$161/$201
Caesar's Boardwalk Regency	$70.00	$70.00	Rates quoted upon request
Claridge Hotel	$65.00	$65.00	Rates quoted upon request

Rates subject to 12% state and local taxes

ALL hotel reservations for the 217th Annual Meeting, MSNJ, will be handled by the Atlantic City Convention Bureau. Please send your housing application directly to the Bureau, 16 Central Pier, Atlantic City, NJ 08401. Complete your 1st, 2nd, and 3rd choices of hotel. All Delegates and Members are urged to make their hotel reservations early. Blocks of rooms will be available at Resorts International (headquarters hotel), the Claridge Hotel and Casino, and Caesar's Boardwalk Regency. The reservations deadline at all three hotels is March 29, 1983. All registrants will be charged for three nights: Friday, Saturday, and Sunday, April 29, April 30, and May 1, 1983.

MAIL THIS APPLICATION DIRECTLY TO THE ATLANTIC CITY CONVENTION BUREAU
16 Central Pier
Atlantic City, NJ 08401

Please list 1st, 2nd, and 3rd choices; confirmation will come directly from hotel.

1st Choice _____ 2nd Choice _____

3rd Choice _____

Accommodations desired: ☐ Single ☐ Twin ☐ Suite Parlor & 1 Bedroom
☐ Suite Parlor & 2 Bedrooms

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Will arrive _____ (date) Time _____ Will depart _____ (date) Time _____

☐ Check if Official Delegate _____ County _____

Medical Sidelights

JOSEPH H. KLER, M.D., New Brunswick

Christiaan Frederik Louis Leipoldt (1880-1947) was born in South Africa, the son of a Dutch Reformed minister. He was educated in South Africa and during the Anglo-Boer War was an overseas correspondent for several pro-Boer newspapers in Europe.

After the war he spent 17 years on the Continent traveling and reporting, and then went to London to study medicine at Guy's Hospital, becoming the editor of the magazine, *The Hospital.*



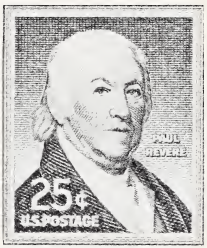
Leipoldt
South Africa, 1980

After receiving a medical degree, Dr. Leipoldt went to Berlin for postgraduate studies in orthopedics and to Graz for pediatrics. Dr. Leipoldt also studied in the United States, served as a ship's doctor, and a school doctor, and returned to South Africa to become head of the Medical Inspectorate of Schools in Transvaal.

From 1924 to 1926, Dr. Leipoldt practiced pediatrics in Cape Town and in 1926 became editor of the *South Africa Medical Journal.* Literature was his main interest in life. He was well known as an author, poet, and playwright and one of the most important literary figures in the Afrikaans language movement.

Paul Revere (1735-1818) was born in Boston and learned the trade of gold and silversmith in his father's shop. He was a true patriot, engraved anti-British caricatures, was a leader in the Boston Tea Party, and induced the colonists to attack and capture Fort William and Mary which was one of the first acts of military force in the war (his "Midnight Ride" from Charleston to Lexington is his most famous exploit).

In 1775, the Massachusetts Provincial Congress sent Revere to Philadelphia to study the only powder mill in America



Revere
United States, 1958

and on his return he did set up a powder mill in Canton, Massachusetts, rose to the rank of lieutenant colonel in the artillery. As a grand master of the Masonic fraternity, he laid the cornerstone of the new State House in Boston.

Revere became a skilled gold and silversmith. He replaced missing teeth, sold spectacles, and made surgical instruments. He was a dental preceptor of John Baker and took over his practice of dentistry in Boston.

In 1776, Revere identified the body of Dr. Joseph Warren by a dental appliance. (Dr. Warren was buried during the battle of Bunker Hill.) This was the first case in America of identification by means of teeth.

MEDICAL HISTORY

Mortar and Pestle

PAUL B. SHELDON, M.D., Princeton*

To anyone interested in medical history, collecting old medical instruments and objects used by nurses, pharmacists, and veterinarians of the past is very appealing. Of course, once having acquired something of the sort, one presumably will read up on when, where, how, and for what it was used. Until recently, books on the subject were to be found in medical libraries, in old instrument catalogues, and in an occasional modern pharmaceutical advertisement.

In 1979, Elizabeth Bennion produced a book, *Antique Medical Instruments* for Sotheby Parke Bernet of London (University of California Press, $65). It is comprehensive, authentic, beautiful, and expensive.

On the chance that some readers of *The Journal* may be interested in collecting medical memorabilia, something on the subject will appear from time to time in these pages.

Perhaps a good object to begin with is the once much-used mortar and pestle. In the course of extracting medicinal material from leaves, seeds, stems, and roots of plants and trees, it often was necessary to first mash them up. This was commonly done by using a wooden or metal mortar and pestle (Figure). When a pharmacist or physician was preparing powders or pills, he used a glass or china mortar and pestle.



Figure—Wooden mortar and pestle.

*Correspondence may be addressed to Dr. Sheldon, *The Journal*, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

LETTERS TO THE EDITOR

Home Health Agency Assembly of New Jersey

November 18, 1982

Dear Dr. Krosnick,

Forty years ago, many sick people were cared for at home. Only in the past few decades have these persons—young and old—been uprooted to nursing homes and health care centers. For this reason, home health agencies offer a variety of services that make it possible for patients, when appropriate, to be treated at home. When these patients participate in their own treatment, with help from their families and qualified health agency staff, their rehabilitation often is speedier and more complete.

The Home Health Agency Assembly of New Jersey, based in Princeton, is an umbrella group that provides information on agencies available statewide, and is offering an information and referral service about home health care and hospice care. The referrals are handled by a toll-free 800-number (800-582-5969) and direct the needy to the agencies nearest them. This number operates only in New Jersey. The Assembly thinks it would be a tremendous help if physicians were aware of this service and could inform the public.

Governor Kean stated that "home health care may suit many persons' financial needs better than institutional care." And this is true: costs for these services may be covered by Medicaid, Blue Cross, or some private insurance plans.

It comes down to a question of how we feel about people. Do we want them to have dignity? Do we want them to be independent? Do we want them to keep their family and community ties? Please help the Assembly provide the needed information to those who are ill or disabled and who are choosing to be treated at home in familiar and comfortable surroundings. Thank you.

Pamela Hawks
Home Health Agency Assembly
of New Jersey

Self-Examination of the Breasts

November 15, 1982

Dear Doctor Krosnick:

It is important that a woman become familiar with the character and contour of her own breasts. She must become accustomed to the cyclic variation in her breast glands related to the time in her menstrual cycle. Should she feel some variation from the familiar, usual contour, she should seek medical advice.

Complicated instructions for self-examination of the breasts frequently are rejected by women. A very simple method of self-examination has been devised, and has been taught and well received by women at all ages.

While bathing or showering, the woman supports her right breast from below with the open palm of her right hand. She washes the right breast and axilla with the open palm and fingers of the left hand, without a washcloth. For the left breast, the reverse, support the breast with the left hand and wash the breast and axilla with the right hand.

Thus, the woman is feeling the breast and axilla every time she bathes or showers and becomes familiar with the "feel" of her own breasts and axillae.

(signed) Lewis E. Savel, M.D.

Physician-Administered Injections

December 6, 1982

Dear Dr. Krosnick:

I particularly was struck by the pious hypocrisy both expressed and latent in the letter of Mr. Edwards ("Physician-Administered Injections," November, 1982). It seems to me that any explanation of a humane method of killing which also does "not take away from the dignity of the state," strikes a macabre and gruesome note.

Therefore, the fact noted twice in the letters, that the lethal medication is administered via a sterile solution, does not come as a surprise. To emphasize that a sterile technique is being used to kill a human being, only fortifies a belief that we do live in an Alice in Wonderland world, where most everything has rotated 180°.

My wife suggests that we now are in a position to add to community-acquired and nosocomial, a new classification: postmortem infections.

Finally, I wish to thank the Society and Dr. Slobodien for his editorial (November, 1982) reiterating the fact that we practice to maintain, not destroy, life.

(signed) Richard L. Franklin, M.D.

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PERSONAL ITEMS

Dr. Muir Installed as President of New Jersey Chapter-ACS

William R. Muir, M.D., Chief of Surgery at Burlington County Memorial Hospital, Mount Holly, has been named President of the New Jersey Chapter of the American College of Surgeons.

Dr. Muir was graduated from Columbia University College of Physicians and Surgeons in 1954. He is a Fellow of the American College of Surgeons, a Diplomate of the American Board of Surgeons, and a member of our Burlington County component. Dr. Muir served as president of the Burlington County Medical Society and the medical staff of Burlington County Memorial Hospital. In addition to his private practice in Mount Holly, Dr. Muir is affiliated with Zurbrugg Memorial Hospital, Riverside, and Deborah Heart and Lung Center, Browns Mills.

Dr. Falla Elected Vice-President of New Jersey Chapter-ACS

Anita Falla, M.D., a member of our Essex County component, was elected Vice-President of the New Jersey Chapter of the American College of Surgeons. Dr. Falla is the first woman elected to this office.

Dr. Falla earned a medical degree at the State University of New York in 1950. She is Chief of Pediatric Surgery, Children's Hospital, Newark. Dr. Falla is affiliated with Saint Michael's Medical Center and University Hospital, both in Newark. She is a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons.

Dr. Tyrrell Named Distinguished Physician

Eugene J. Tyrrell, M.D., has been named the recipient of the 3rd Annual Distinguished Physician Award presented by the Board of Directors of the Raritan Bay Health Services Corporation (RBHSC). RBHSC comprises Perth Amboy General and Old Bridge Regional Hospitals.

Dr. Tyrrell, a member of our Middlesex County component, is a specialist in internal medicine with a private practice in his native Perth Amboy. He received his medical degree from New York University in 1951; he served his internship and residency in internal medicine at Newark City Hospital. Dr. Tyrrell, who has been a member of the medical staff of RBHSC since 1953, has served as secretary-treasurer from 1975 to 1977 and is the immediate past president of the medical staff, as well as past president of the Middlesex County Medical Society.

As he presented the award to Dr. Tyrrell, Ernest R. Hansen, Chairman of the RBHSC Board of Directors, stated, "Dr. Tyrrell's concern for our hospitals does indeed justify this honor in recognition of his efforts to promote medical staff, administration, and board of directors solidarity."

Dr. Kellerman Honored by ACP

Alan Kellerman, M.D., a member of our Camden County component, has been elected to Fellowship in the American College of Physicians. Dr. Kellerman earned a medical degree from Hahnemann Medical College, Philadelphia, in 1962. A specialist in medicine-cardiology, Dr. Kellerman is on the staff of the West Jersey Hospital's Berlin and Camden divisions.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physician Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately, the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

THE DEPARTMENT OF PROFESSIONAL LIABILITY CONTROL

of the
MEDICAL SOCIETY OF NEW JERSEY
presents

A REPEAT OF THE MEDICOLEGAL SEMINAR

PROFESSIONAL LIABILITY: WHAT'S AHEAD FOR THE NEW JERSEY PHYSICIAN

Wednesday, March 23, 1983

MEDICAL SOCIETY OF NEW JERSEY
Executive Offices
Two Princess Road
Lawrenceville, New Jersey 08648

Registration & Coffee 8:30

Morning Session 9:00 a.m.-12:00 p.m.

OPENING REMARKS
Howard D. Slobodien, M.D.
President, Medical Society of New Jersey

"A SURVEY OF PROFESSIONAL LIABILITY"
James E. George, M.D., J.D.
Director, Department of Professional Liability Control, Medical Society of New Jersey

"CLAIMS AND SUITS: WHAT'S HAPPENING"
Peter Sweetland, President
New Jersey State Medical Underwriters, Inc.

"PROFESSIONAL LIABILITY AND THE ROLE OF THE STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY"
Joseph A. Riggs, M.D.
Member State Board of Medical Examiners
Joan Gelber, Esq.
Deputy Attorney General

Lunch 12:00 p.m.-12:45 p.m.

Afternoon Session 12:45 p.m.-4:00 p.m.

"PROFESSIONAL LIABILITY AND THE ROLE OF THE NEW JERSEY DEPARTMENT OF INSURANCE"
Warren P. Cooper, Chief Actuary
Property/Liability, New Jersey Department of Insurance

"AN UPDATE OF *RULE 4:21* PANEL HEARINGS"
Frances K. Boronski, Esq.
Chief, Civil Court Services Administrative Office of the Courts

"AN ALTERNATIVE: PROPOSED PROFESSIONAL LIABILITY LEGISLATION"
Vincent A. Maressa, Executive Director
Medical Society of New Jersey

Watch your mail for registration information or call the Medical Society of New Jersey for advance registration: (609) 896-1766.

Registration Fee:

Nonmembers of MSNJ	$25.00	**LIMITED TO THE**
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CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, The Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Mar.

24th Annual NJ Postgraduate Anesthesia Seminar

19 8 a.m.-4:30 p.m.

20 8:30 a.m.-12 noon—Hyatt House, Cherry Hill
(NJ State Society of Anesthesiologists and AMNJ)

CARDIOLOGY

April

13 Indications for Invasive Cardiac Studies
11:30 a.m.-12:30 p.m.—Rahway Hospital
(AMNJ)

MEDICINE

Mar.

2 Medical Grand Rounds
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

2 Dinner Meeting
6-9:30 p.m.—Holiday Inn, Newark Airport
(Endocrinology Section of AMNJ)

2 New Infectious Disease Syndromes

9 Diagnosis and Management of Acute Renal Failure

16 Magnesium and Phosphate Depletion

23 Pathophysiology of the Chronic Obstructive Lung Diseases
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

2 Internal Medicine Review Course

9 3-6 p.m.—Clara Maass Medical Center,

16 Belleville

23 *(Clara Maass Medical Center and*

30 *AMNJ)*

2 Endocrine Conferences

9 3:30-5 p.m.—Rotates between Newark

16 Beth Israel Medical Center, University

23 Hospital, United Hospital Medical

30 Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

2 Observation in Art and Medicine

9 Anaerobic Infections in the Elderly and Their Management

16 To be announced

30 To be announced
9:30-11 p.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

2 Preop Planning for the Surgical Patient—Part I

16 Part II

30 Approach to the Patient with Dizziness
12:30-2:30 p.m.—Rutgers Community Health Plan, Route 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

3 Medical Grand Rounds
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section of AMNJ)

3 Congenital Adrenal Hyperplasia
9 a.m.—Freehold Area Hospital
(AMNJ)

4 Medical Grand Rounds
11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section of AMNJ)

4 Renal Conferences in Nephrology

18 4-5 p.m.—University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section of AMNJ)

8 Diabetes
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

9 Sexually Transmitted Diseases

23 Biliary Stone Saga: Endoscopic Removal of Gallstones
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

9 The Medical and Physical Aspects of Eating and Dieting
8-9 p.m.—484 Old Short Hills Rd., Short Hills
(NJ Medical Woman's Association, Essex County Medical Society, Women's Journal Club, and AMNJ)

10 The Present Status of the Computer: Optimizing Health and Medical Problem Solving
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

11 Newer Therapeutic Agents
12:15-1:15 p.m.—J.F. Kennedy Memorial Hospital, Stratford
(UMDNJ-School of Osteopathic Medicine, J.F. Kennedy Memorial Hospital, and AMNJ)

11 Diagnosis of Viral Illness in a Community Hospital
8:15-9:45 a.m.—Overlook Hospital, Summit
(Overlook Hospital, Columbia University College of Physicians and Surgeons, and AMNJ)

12 Medicolegal Symposium on Emergency Care
9:30 a.m.-4:15 p.m.—Hyatt Hotel, New Brunswick
(American College of Emergency Physicians, NJ Affiliate American Heart Association, and AMNJ)

12 The Painful Triangle—Office Management of Head, Neck, and Shoulder Disorders
8 a.m.-5 p.m.—J.F.K. Professional Mall, Stratford
(UMDNJ and AMNJ)

15 Current Burn Therapy
12 noon—St. Mary's Hospital, Orange
(AMNJ)

15 Drug-Induced Acute Interstitial Nephritis
4-5 p.m.—Academic Health Science Center Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

16 Joint Conference
9 a.m.-3:45 p.m.—Coachman Inn, Cranford
(NJ Thoracic Society, NJ Chapter, American College of Chest Physicians, and AMNJ)

16 Rutgers Dermatological Conferences
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

17 Clinical Syndromes Related to Gastrointestinal Gas
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

18 CDS Prescribing Practices
1:15-2:15 p.m.—Marlboro Psychiatric Hospital
(AMNJ)

21 Nephritis
12 noon-1 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)

22 American Medical Society of Andrology

23 National Meeting

24 Independence Holiday Inn, 4th and Arch

25 Sts., Phila.
(Cooper Medical Center and AMNJ)

22 Blood Banking Seminar
2-5 p.m.—Rutgers Medical School, Piscataway
(NJ Blood Services and AMNJ)

23 Medical Complications of Pregnancy
12:30-2:30 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick

The Academy of Medicine of New Jersey
New Jersey Institute of Ultrasound in Medicine
Radiological Society of New Jersey

present a symposium on

"COMPUTERS IN RADIOLOGY"

on

Saturday, March 19, 1983

at

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The program will include presentations by nationally prominent speakers on the use of computer systems for data acquisition and analysis in nuclear medicine; radiology management—the RISC update; image management—the fiber optic approach; computer analysis of ultrasound echoes; the computer and axial tomography; and the personal computer in the radiology office. This program is designed for radiologists, technicians and other allied professionals working in the field.

For further information contact:
Linda Bartolo
Academy of Medicine of New Jersey
Two Princess Road
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CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

WEDNESDAY, MARCH 2, 1983

20 minute lectures—Questions and Answers (10 minutes)
MODERATOR: BERNARD L. SEGAL, M.D.

SELECTION OF PATIENTS FOR CORONARY BYPASS SURGERY: 1983
Bernard L. Segal, M.D.

THE ROLE OF CALCIUM-CHANNEL BLOCKING AGENTS IN THE MANAGEMENT OF CORONARY HEART DISEASE
David T. Lowenthal, M.D.

ELECTROPHYSIOLOGIC EVALUATION OF SUPRAVENTRICULAR TACHYCARDIA—CASE PRESENTATION
Allan M. Greenspan, M.D.

FOLLOW-UP OF PATIENTS WITH PROSTHETIC HEART VALVES
Gary S. Mintz, M.D.

CASE PRESENTATION/DISCUSSION
Edward Catherwood, M.D.

3:00 PM—2nd floor New College Building, Hahnemann University
• NO REGISTRATION FEE • NO ADVANCE REGISTRATION REQUIRED •
• CME CATEGORY I CREDITS CERTIFIED •
WINE & CHEESE SERVED FOLLOWING CONFERENCE

(Rutgers Community Health Plan and AMNJ)

23 Morbid Obesity
9:30-11:30 a.m.—Riverside Hospital, Boonton
(Riverside, St. Clare's, Dover General Hospital, and AMNJ)

23 Renal Adaption to Low Potassium Intake
7:30-8:30 p.m.—Ramada Inn, Clark
(Nephrology Society and AMNJ)

24 Clinical Pharmacology of the Antibiotics

31 Chronic Obstructive Lung Disease
11 a.m.-12:30 p.m.—St. Joseph's Hospital & Medical Center, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

24-27 Thirty-first Annual Convention
Golden Nugget Hotel, Atlantic City
(NJ Academy of Family Physicians)

30 Symposium on Drug Allergy
9-11:30 a.m.—Muhlenberg Hospital, Plainfield
(NJ Allergy Society and AMNJ)

April

1 Renal Conferences in Nephrology

15 4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section of AMNJ)

2 Gallstone Dissolution
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

2 Intraocular Lenses and YAG Laser
8 a.m.-2 p.m.—Eye Institute of New Jersey, Newark
(UMDNJ and Eye Institute of New Jersey)

5 Immunology
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

6 Thromboembolism and Thrombolytic Therapy
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

6 Medical Grand Rounds
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

6 Coma and Survival
1-5 p.m.—Saint Barnabas Medical Center, Livingston
(AMNJ)

6 Dinner Meeting
6-9:30 p.m.—Holiday Inn, Newark Airport
(Endocrinology Section of AMNJ)

6 Eye Manifestations of Systemic Disease

27 Principles of Dermatologic Therapy
12:30-2:30 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

6 Endocrine Conferences

13 3:30-5 p.m.—Rotates between Newark

20 Beth Israel Medical Center, University

27 Hospital, United Hospitals, Newark, and VA Medical Ctr., East Orange
(Endocrinology Section of AMNJ)

6 1983 Internal Medicine Review Course

13 3-6 p.m.—Clara Maass Medical Center,

20 Belleville

27 *(Clara Maass Medical Center and AMNJ)*

7 Medical Grand Rounds
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section of AMNJ)

8 Medical Grand Rounds
11:30 a.m.—University Hospital, Newark
(Endocrinology Section of AMNJ)

8 Current Clinical Concepts in Rheumatology Immunology
12:15-1:15 p.m.—J.F. Kennedy Memorial Hospital, Stratford Div.
(UMDNJ, J.F. Kennedy Memorial Hospital, and AMNJ)

7 Leukocyte Abnormalities
9 a.m.—Freehold Area Hospital
(AMNJ)

8 Management of Acute Renal Failure
8:15-9:45 a.m.—Overlook Hospital, Summit
(Overlook Hospital, Columbia University College of Physicians and Surgeons, and AMNJ)

8 A New Approach to the Diagnosis of Thyroid Nodules
8-9 p.m.—Rancocas Valley Hospital, Willingboro
(Burlington County Medical Society and AMNJ)

Menstruation

8-9 9 a.m.-5 p.m.—Resorts International, Atlantic City

9 9 a.m.-12 noon
(UMDNJ)

13 Dermatologic Lesions in Internal Medical Diseases
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

13 Vasculitis: Polyarteritis and Fever of Unknown Origin
9:30-11:30 a.m.—Riverside Hospital, Boonton
(Riverside, St. Clare's, Dover General Hospitals and AMNJ)

13 Update in Dermatology
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

13 Management of Infection in the Immunodeficient Patient

20 Sarcoidosis and Other Forms of Interstitial Lung Disease
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

16 Clinical Approach to Rehabilitation of Sports and Spinal Cord Injuries
9 a.m.-5 p.m.—Lawrenceville School, Lawrenceville
(NJ Society of Physical Medicine and Rehabilitation, American Academy of Physical Medicine and Rehabilitation, St. Lawrence Rehabilitation Center, and AMNJ)

16 New Concepts in the Pathogenesis of Emphysema
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

19 Hypertension
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

19 Drug-Induced Disturbances of Water, Electrolyte, and Acid Base Balance
4-5 p.m.—Academic Health Science Center, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

19 Nephrology Lectures
7:30-8:30 p.m.—Ramada Inn, Clark
(Nephrology Society and AMNJ)

20 Occurrence and Resurgence of Zoonosis
9:30 a.m.-3 p.m.—Sheraton Hotel, East Brunswick
(NJ Public Health Assoc., NJ Veterinary Medical Society, NJ State Dept. of Health, MSNJ, and AMNJ)

20 Fluid and Electrolyte Imbalance
10:30-11:30 a.m.—South Bergen Hospital, Hasbrouck Heights
(AMNJ)

20 Rutgers Dermatological Conferences
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

21 Hypertension-Diabetes: A Clinical Dilemma in Management
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

23 Geriatrics—Practical Office Management
8:15 a.m.-4:15 p.m.—J.F.K. Professional Mall, Stratford
(UMDNJ and AMNJ)

28 Immunologic Aspects of Infectious Diseases
11 a.m.-12:30 p.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

28 Dinner Meeting
7 p.m.—Overlook Hospital
(NJ Gastroenterological Society and AMNJ)

NEUROLOGY/PSYCHIATRY

Mar.

2 Pharmacology of Antipsychotic Agents

23 3-4 p.m.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

2 Child Psychiatry Case Conference

9 10 a.m.-12 noon—Trenton Psychiatric

16 Hospital

23 *(Trenton Psychiatric Hospital and*

30 *AMNJ)*

3 Factitious Disorders Including Munchausen Syndrome

17 Behavioral Therapy and Alcoholism

31 Lithium: Recent Advances
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

7 Neuroscience Conferences

14 11:30 a.m.-12 p.m.—Bergen Pines

21 County Hospital, Paramus

28 *(Bergen Pines County Hospital and AMNJ)*

7 Pathologic Love
8:15-10:30 p.m.—39 Crescent Ave., Passaic
(Essex Psychiatric Seminar and AMNJ)

7 Psychiatry Case Conference

14 7:30-11:30 a.m.—Trenton Psychiatric

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Update in Internal Medicine

April 20-22, 1983

A 3-day intensive symposium sponsored by the Department of Medicine, Jefferson Medical College, 1025 Walnut Street, Philadelphia, PA.

Willis C. Maddrey, M.D., Course Director

A registration fee of $375 includes course syllabus and reception-dinner at the Philadelphia Hershey Hotel.

For further information, call Office of CME (215-928-6992)

UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY
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DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

MENSTRUATION

The Physiology and Pathology of the Menstrual Flow and the Effects of Hygiene Products

APRIL 8-9, 1983
Resorts International Hotel
Atlantic City, New Jersey

This one-and-a-half day conference is designed to acquaint you with the current knowledge of the menstrual flow, with special attention given to what is known about the toxic shock syndrome. Through lectures, panel discussions and audience interaction, many questions you have regarding menstruation will be clarified. In addition, the use of hygiene products — which has rarely been addressed at a medical meeting — will be reviewed.

Topics Include: Normal Parameters of Menstruation • Factors Affecting the Menstrual Flow (diet, exercise, stress, illness) • Fertility Control Measures • Design and Function of Hygiene Products • Menses and Inflammatory Disease.

For a Comprehensive Program: Please contact Patricia Reid, UMDNJ-Rutgers Medical School, Box 101, Piscataway, NJ 08854 (201) 463-4707.

Clinical Nutrition Update

Seventh Annual Nutrition Symposium

April 5–7, 1983

University of Pennsylvania School of Medicine

The Philadelphia Veterans Administration Medical Center

The purpose of this program is to provide the practicing physician, clinical nutritionist, nurse and pharmacist with a clinical approach to commonly encountered diagnostic and therapeutic problems in adult clinical nutrition.

Discussion Topics:
Enteral Alimentation, Micronutrient Metabolism, Nutritional Assessment, Obesity, Cancer, Renal Dysfunction, Diabetes Mellitus, Nutrient Delivery Techniques, Home Nutritional Support, Metabolic Monitoring, and Nutrition Misinformation and Faddism.

Course Director:
James L. Mullen, M.D., Chief, Surgical Service, Philadelphia VA Medical Center, Director, Nutrition Support Service, Hospital of the University of Pennsylvania, Associate Professor of Surgery, University of Pennsylvania.

Educational Coordinator:
Wanda F. Hain, R.D., M.Ed.

Continuing Education Credits
Approval has been granted for credits for dietitians, nurses, pharmacists, and physicians

Registration Fee: $90

Guest Faculty:
George Blackburn, M.D., Ph.D.,
W. Arthur Burke, Pharm.D.,
Edward Copeland, M.D.,
Victor Herbert, M.D., J.D.,
Khursheed Jeejeebhoy, M.D., Ph.D.,
Carey Page, M.D.,
Eliot Stellar, Ph.D.,
Albert Stunkard, M.D.,
Eleanor Young, R.D., Ph.D.

For Information and Registration, contact:
Office of Continuing Medical Education
School of Medicine/G3
University of Pennsylvania,
Philadelphia, PA 19104
(215) 898-8005

21 Hospital
28 *(Trenton Psychiatric Hospital and AMNJ)*

10 **Multidisciplinary Approach to Cerebrovascular Insufficiency**
8-9 p.m.—Burlington County Memorial Hospital, Mt. Holly
(Burlington County Medical Society and AMNJ)

11 **Joint Meeting with NJ Psychoanalytic Society**
8:30-10:30 p.m.—Atrium West, West Orange
(New Jersey Psychiatric Association and AMNJ)

11 **Psychiatric Lecture Series**
18 1:30-5 p.m.—Trenton Psychiatric
25 Hospital
(Trenton Psychiatric Hospital and AMNJ)

12 **Mental Health of Korean American Children**
5:30-6:30 p.m.—Sheraton Heights Hotel, Hasbrouck Heights
(Korea University College of Medicine Alumni Association and AMNJ)

17 **Cerebral Vasospasms**
4-5:30 p.m.—UMDNJ-NJ Medical School University Hospital, Newark
(UMDNJ and AMNJ)

21 **Principles of Child Psychotherapy**
8:30-10:30 p.m.—Office of Dr. Deutsch, 301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

22 **Laboratory Interpretations**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

April

4 **An Uncommitted Lesbian**
8:15-10:30 p.m.—5 Fairfield St., Montclair
(Essex Psychiatric Seminar and AMNJ)

217th Annual Meeting
April 29–May 2, 1983

Resorts International
Atlantic City, New Jersey

Daily Schedule

Friday, April 29, 1983
3:30 p.m.—Board of Trustees' Meeting
5:00 p.m.—Delegate Registration
7:00 p.m.—Officers' Cocktail Reception followed by Dinner

Saturday, April 30, 1983
7:30 a.m.—Delegate Registration
9:00 a.m.—House of Delegates
9:00 a.m.—Message Center, Scientific, Informational, and Insurance Exhibits Open
10:30 a.m.—House of Delegates (election)
12:00 noon—Golden Merit Award Ceremony followed by Reception
1:00 p.m.—Reference Committee Meetings
5:00 p.m.—JEMPAC Political Forum
5:45 p.m.—JEMPAC Wine and Cheese Reception

Sunday, May 1, 1983
8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—Scientific Sessions
12:00 noon—Luncheons
1:00 p.m.—Scientific Sessions
6:30 p.m.—Inaugural Reception followed by Inaugural Dinner

Monday, May 2, 1983
6:30 a.m.—County Society Breakfast Caucuses
8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—House of Delegates
12:00 noon—Message Center, Scientific, Informational, and Insurance Exhibits Close
12:00 noon—House Adjourns for Lunch
1:30 p.m.—House Reconvenes
3:00 p.m.—Board of Trustees' Meeting

4 **Neuroscience Conferences**
11 11:30 a.m.-12:30 p.m.—Bergen Pines
18 County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

4 **Psychiatric Case Conferences**
11 7:30-11:30 a.m.—Trenton Psychiatric
18 Hospital
25 *(Trenton Psychiatric Hospital and AMNJ)*

6 **Encephalopathies: Organic Causes of Mental Dysfunction**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

6 **The Close Alcoholic Presenting as a Psychiatric Patient**
3-4:30 p.m.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)

6 **Clinical Toxicity of Antidepressants**
27 **Family Therapy**
3-4 p.m.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

6 **Symposium on Developmental/Behavioral**
7 **Disorders: Update 1983**
8 8 a.m.—Meadowlands Hilton, Secaucus
9 *(Hackensack Medical Center and AMNJ)*

7 **Alzheimer's Disease: An Update**
14 **New Concepts in Multiple Sclerosis**
12 noon-1 p.m.—Carrier Foundation, Belle Mead

6 **Child Psychiatry Case Conferences**
13 10 a.m.-12 noon—Trenton Psychiatric
20 Hospital
27 *(Trenton Psychiatric Hospital and AMNJ)*

8 **Psychiatric Lecture Series**
15 1:30-5 p.m.—Trenton Psychiatric
22 Hospital
29 *(Trenton Psychiatric Hospital and AMNJ)*

13 **Third Samuel B. Kutash Memorial Lecture**
Nuclear War: Psychological Aspects of Prevention
7:30 p.m.—South Orange Middle School, South Orange
(Mental Health Assn. of Essex County)

18 **Principles of Child Psychotherapy**
8:30-10:30 p.m.—Office of Dr. Deutsch, 301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

19 **Drug Therapy of Depression**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

20 **Assessment of Suicidal Risk**
12:30-2:30 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

26 **Clinical Problems in Sexual Development**
8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

29 **Treating Children with Psychogenic Behavior Disorders and Psychogenic Learning Disorders**
9 a.m.-5 p.m.—Harrah's Marina Hotel Casino, Atlantic City
(Cumberland County Guidance Center and AMNJ)

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 25-hour accredited seminar and workshop on the latest theories & techniques of manual and electro-acupuncture, applicable toward the 100-hour requirement for certification, will be given for licensed clinicans (with or without prior training) during the weekend of March 25-27, 1983 and again the weekend of June 24-26, 1983 at the Barbizon Plaza Hotel, New York City. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its official journal (published by Pergamon Press) the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital. Also eligible for AMA/CME credit. For information, contact Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I), NYC 10032. Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.

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As an organization accredited for continuing medical education, the Jefferson Medical College designates this continuing medical activity as meeting the criteria for 20 credit hours in Category I of the Physician's Recognition Award of the American Medical Association.

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FOR INFORMATION WRITE:

HAROLD J. ROBINSON, M.D.
Director, Main Line Conference
The Bryn Mawr Hospital
Bryn Mawr, Pennsylvania 19010

Registration Fee: **$175.00**
(includes 3 luncheons, cocktails and dinner)

OBSTETRICS/GYNECOLOGY

Mar.

11 **Semmelweis-Waters Obstetrical/Gynecological Conference**
12 8 a.m.-5:50 p.m.—Resorts International,
13 Atlantic City
(UMDNJ and AMNJ)

PATHOLOGY

Mar.

3 **Crown Gall**
10 **Insect Hormones**
17 **Cell Models**
24 **Teratocarcinoma**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

23 **Clinical Pathology Conference**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

April

7 **Cell Biology**
14 4-6 p.m.—Institute for Medical Research, Copewood St., Camden
28 *(Institute for Medical Research and AMNJ)*

PEDIATRICS

Mar.

19 **Sports-Related Injuries in Children and Adolescents**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

22 **Cancer in Childhood**
8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

April

18 **Pediatric Lecture Series**
12 noon-1 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)

20 **Childhood Diabetes**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

27 **Common Problems in Adolescent Medicine**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

RADIOLOGY

Mar.

3 **Columbia Affiliate Radiology Lecture Series**
5:30-6:30 p.m.—Overlook Hospital
(Morristown Memorial Hospital, Overlook Hospital, and AMNJ)

16 **Dinner Meeting**
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

19 **Computers in Radiology**
8 a.m.—Sheraton Inn, Newark Airport
(NJ Institute of Ultrasound in Medicine, Radiological Society of NJ, and AMNJ)

31 **Visiting Professor Program**
1:30-5 p.m.—Saint Barnabas Medical Center, Livingston
(Dept. of Radiology, Saint Barnabas Medical Center and AMNJ)

April

7 **Columbia Affiliate Radiology Lecture Series**
5:30-6:30 p.m.—Morristown Memorial Hospital
(Morristown Memorial Hospital, Overlook Hospital, and AMNJ)

21 **Joint Meeting**
7:15 p.m.—Saint Barnabas Medical Center, Livingston
(NJ Institute for Ultrasound in Medicine, Radiological Society of NJ, and Diagnostic Radiology Section of AMNJ)

21 **Nuclear Magnetic Resonance Imaging**
7:30-9:30 p.m.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine, Radiological Society of NJ and AMNJ)

SURGERY

Mar.

2 **Breast Cancer**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

2 **In and Out Surgery**
11:30 a.m.—Columbia Hospital, Newark
(AMNJ)

9 **Alternative to Standard Ileostomies**
9:30-11:30 a.m.—Riverside Hospital, Boonton
(Riverside, St. Clare's, Dover General Hospitals, and AMNJ)

9 **Statewide Tumor Board Conference**
5:30 p.m.—Academy of Medicine of NJ, Lawrenceville
(Oncology Society of NJ)

16 **High-Risk Surgery**
11:30 a.m.-12:30 p.m.—Rahway Hospital
(AMNJ)

16 **Lumpectomy and Radiation: Treatment of Early Breast Cancer**
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

22 **Management of Breast Cancer**
6:30-10 p.m.—Coachman Inn, Cranford
(NJ Blood Club and AMNJ)

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastics, and Vascular Surgery)

Mar.

5 **The Back Is Back**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

16 **Dinner Meeting**
6:30-9:30 p.m.—The Manor, West Orange
(NJ Society of Colon and Rectal Surgeons and AMNJ)

22 **Advances in Head and Neck Surgery**
8-10 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

30 **Head and Neck Cancer**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

April

2 **Intraocular Lenses and YAG Laser**
8 a.m.-2 p.m.—Eye Institute of New Jersey, Newark
(UMDNJ and Eye Institute of New Jersey)

9 **8th Annual Orthopaedic Symposium**
8:30 a.m.—UMDNJ-Rutgers Medical School, Piscataway
(AMNJ)

26 **Sports Medicine in the Over-35 Professional**
8-10 p.m.—Englewood Club, 115 E. Palisade Ave., Englewood
(Englewood Surgical Society and AMNJ)

MISCELLANEOUS

Mar.

2 **Toxicology Seminars**
16 3 p.m.—Rutgers Medical School,
23 Piscataway
30 *(UMDNJ)*

April

6 **Toxicology Seminars**
13 3 p.m.—Rutgers Medical School,
20 Piscataway
27 *(UMDNJ)*

OBITUARIES

Dr. Harry R. Aronis

Harry Robert Aronis, M.D., a member of our Mercer County component, died on November 22, 1982. Born in 1905 in Trenton, Dr. Aronis earned a medical degree at University of Pennsylvania Medical School, in Philadelphia, in 1928. Dr. Aronis was a pediatrician in Mercer County for over 40 years before his retirement in 1977. During his career, Dr. Aronis was affiliated with Mercer Medical Center, Trenton. He was a member of the American Medical Association.

Dr. Jacob Averbach

At the grand age of 81, Jacob Averbach, M.D., died on November 11, 1982. Dr. Averbach was graduated from University of Pennsylvania Medical School, Philadelphia, in 1926. He was the oldest member of the medical staff at Beth Israel Hospital, Passaic. Dr. Averbach also was affiliated with Barnert Hospital, Paterson. He was a member of the American Medical Association. Dr. Averbach served with the United States Navy during World War II and was a retired captain in the United States Naval Reserve.

Dr. George R. Booth

George R. Booth, M.D., died on December 13, 1982. Born in 1906, Dr. Booth was graduated from Temple University School of Medicine, Philadelphia, in 1935. During his career, Dr. Booth was affiliated with State Hospital, Ancora, Cooper Medical Center, Camden, and Underwood-Memorial Hospital, Woodbury. Dr. Cooper was a Diplomate of the American Board of Ophthalmology, a retired member of our Gloucester County component, and a member of the American Medical Association.

Dr. E. Vernon Davis

Elbert Vernon Davis, M.D., the 179th President of the Medical Society of New Jersey, died on December 12, 1982. Born in 1906, Dr. Davis was graduated from Jefferson Medical College, Philadelphia, in 1930. During his lengthy career, Dr. Davis was affiliated with Burlington County Memorial Hospital, Mount Holly, and Zurbrugg Memorial Hospital, Riverside. Dr. Davis was a retired member of our Burlington County component, a member of the American Medical Association, a Diplomate of the American Board of Orthopedic Surgery, and a Fellow of the American College of Surgeons.

Dr. Frederick C. Dittrich

Frederick Conbert Dittrich, M.D., a member of our Essex County component, died late last year. Dr. Dittrich was born in 1920 and received a medical degree from the University of Rochester, New York, in 1945. Dr. Dittrich was affiliated with Memorial Hospital, Orange. Dr. Dittrich was a member of the American Medical Association.

Dr. John Henderson

John Henderson, M.D., died on November 24, 1982, in Princeton. Born in 1906, Dr. Henderson earned a medical degree at Columbia University College of Physicians and Surgeons, New York, in 1932. He was Medical Director of Johnson and Johnson for 26 years, retiring in 1971. Dr. Henderson was a member of our Middlesex County component and of the American Medical Association; he was a Fellow of the American College of Surgeons.

Dr. James J. Hogan

James Joseph Hogan, M.D., died on December 5, 1982. Born in 1915, Dr. Hogan was graduated from Hahnemann Medical College, Philadelphia, in 1935. A lifelong resident of Mount Holly, Dr. Hogan was affiliated with the departments of internal medicine and cardiology at Burlington County Memorial Hospital. Dr. Hogan was a member of our Burlington County component.

Dr. Robert V. Holman

Robert Vogel Holman, M.D., a member of our Passiac County component, died on December 6, 1982. Born in 1916, Dr. Holman earned a medical degree at the State University of Iowa College of Medicine, Iowa City, in 1940. He was director of the department of orthopedics, St. Joseph's Hospital and Medical Center, Paterson. He was affiliated with Chilton Memorial Hospital, Pompton Plains. Dr. Holman was a member of the American Medical Association, a Diplomate of the American Board of Orthopedic Surgery, and a Fellow of the American College of Surgeons and of the American Academy of Orthopedic Surgeons.

Dr. Irving H. Plain

A member of our Essex County component, Irving H. Plain, M.D., died on December 10, 1982. Dr. Plain was born in 1906 in Newark and was graduated from Long Island College of Medicine, New York, in 1931. He was affiliated with Riverside Hospital, Boonton, and Newark Beth Israel Medical Center and St. James Hospital, both in Newark. Dr. Plain was a Diplomate of the American Board of Ophthalmology.

Dr. William M. Sullivan, Jr.

At the age of 80, William M. Sullivan, Jr., M.D., died on December 5, 1982. Dr. Sullivan earned a medical degree at Jefferson Medical College, Philadelphia, in 1929. A family practitioner, Dr. Sullivan was affiliated with Passaic General Hospital since 1932. A member of our Passaic County component, he received MSNJ's Golden Merit Award for 50 years of service to the medical community. He was a past president of the Passaic County Medical Society and a member of the American Medical Association.

Dr. Michael Testa, Jr.

At the untimely age of 49, Michael Leonard Testa, Jr., M.D., died on November 21, 1982. Dr. Testa was graduated from Padau University, Italy, in 1963. At the time of his death, Dr. Testa was Director of Anesthesiology, Riverside Hospital, Red Bank. He was a member of our Monmouth County component.

The American Medical Association Family Medical Guide

Jeffrey R.M. Kunz, M.D., (ed). New York, NY, Random House, 1982. Pp. 831. Illustrated. ($29.95)

The recently published *The American Medical Association Family Medical Guide* is a practical, self-help book. With a readable text, color illustrations and diagrams, step-by-step diagnosis guides, and excellent cross-reference section, *The AMA Family Medical Guide* is an encyclopedic source for everyday mishaps and common illnesses.

This useful, 1980s medical guide covers over 600 diseases and disorders with over 1300 photographs and diagrams. It contains a full color atlas of the body, a drug index, and a home and job safety checklist.

In today's world, it is essential for every household to own an overall guidebook for quick reference. *The AMA Family Medical Guide* covers every conceivable topic from how to keep physically fit, to emergency care, general infections, first aid, and a special section on death and dying in the American health care system.

What makes this self-help text a notch above the others is its comprehensiveness, practicality, and style. It is the perfect book for persons who would like to have a convenient and useful medical text around the house. G.H.

Annual Review of Medicine

William Creger, M.D., (ed). Palo Alto, CA, Annual Reviews, 1982. Pp. 596. ($25)

This book is a collection of recent articles from the literature that encompasses practically all of the medical disciplines. Included in the text are studies of viral diseases (many quite exotic), problems of infection, pharmacology, cardiology, and hematology.

Unfortunately, the editors have not used a guiding light in their work. There is no unifying factor, and *Annual Review of Medicine* is merely a random collection of 39 articles about completely unrelated topics.

There is nothing here that could not be found in more satisfying detail in a standard text or specialty journal.

I would not recommend this book to anyone; it seems to have no raison d'être. In addition, the price is outrageous even by current inflationary standards. Leo Lewin, M.D.

The Encyclopedia of Medical Tests

Cathey Pinckney and Edward R. Pinckney, M.D. New York, NY, Facts on File, 1982. Pp.297. ($14.95)

This volume is written for lay consumers and is intended to give them some background information about the tests which a physician may order.

Included in this information are: what help the test can be in the diagnosis of an ailment, where and how the test will be performed, how much the test will cost, what risks and pain will be entailed, and how reliable is the test.

The authors point out that over two million tests per day are invalid. Because of this, diagnostic errors are made, and this has become the most common complaint in malpractice suits. They also note that almost one-half of our annual health expenditure is spent on tests, and most doctors order more tests than "really necessary."

This reviewer sees little usefulness for this book. It is too technical for the average patient, and provides no new information for the physician. The concept of the average patient "checking up" on his family physician by reading this book whenever he, his relative, neighbor, or friend has testing ordered, does not make sense. Personal dialogue between patient and physician, in nontechnical language, would be much preferred.

Joseph Peyser, M.D.

Endocrine Pathophysiology: A Patient Oriented Approach. Second Edition

Jerome M. Hershman. Philadelphia, PA, Lea & Febiger, 1982. Pp. 316. Illustrated. ($15.75)

The author and contributors to this second edition present the pathophysiology of endocrine diseases for medical students and indeed for any physician with interest in endocrinology. Basic important subject matter is presented nicely in physiologic terms and each chapter concludes with useful illustrative questions and answers. The dialogue clearly states what is known from previous experimental studies and mentions that which is not yet clearly defined. The text is full of information.

However, this is not a book of exhaustive factual data and of all the latest reported work in each subject, but it does supply a great deal of valuable basic endocrine discussion. It accomplishes admirably the physiological understanding of endocrine and metabolic dysfunction. References are quoted at the termination of each chapter for those interested in pursuing a more in-depth study.

Endocrine Pathophysiology: A Patient Oriented Approach is a good background text for use in hospital house staff teaching programs in endocrinology.

Mark M. Singer, M.D.

Hospital-Physician Relationships. Case Studies and Commentaries on Medical Staff Problems

Nathan Hershey, LLB. Rockville, MD, Aspen Systems Corporation, 1982. Pp. 239. ($23.50)

The traditional relationship between hospital boards, administrators, and medical staffs always has been complicated. During the past decade external pressures brought about by judicial decisions, JCAH standards, quality assurance programs, and the perceived physician surplus have injected elements of conflict and controversy into the traditional relationship.

Hospital-Physician Relationships successfully conveys the interpersonal and political dynamics of hospital and medical staff controversies through the use of nine case studies supplemented by insightful commentary. The contributing authors are attorneys whose practice in hospital law has given them insight into effective means of avoiding and resolving conflict in this volatile area of concern to physicians.

The practical, strategic, and legal ramifications of conflict generated by peer review activity, review of applica-

tions to the medical staff, scope of clinical privileges issues, an impaired colleague, and the like are explored in familiar scenarios.

The case studies clearly portray how such problems, if left unresolved or if dealt with in a less than legally effective manner, may mushroom into full-blown litigation involving every member of the medical staff. Not surprisingly, the authors stress the need for preventive legal counsel and the need for carefully drafted medical staff and hospital bylaws. Adherence to the provisions of such documents is shown as a major mechanism by which conflicts can be avoided or reduced.

This book is a must for every physician who is or may become a member of a hospital medical staff.

James E. George, M.D., J.D.

How To Relieve Cramps and Other Menstrual Problems

Marcia Storch, M.D., with Carrie Carmichael. New York, NY, Workman Publishing, 1982. Pp. 131. Illustrated. ($3.95)

Two articulate women, a physician and a journalist, have combined their talents and educational backgrounds to provide their long-suffering sisters with a bubbly Baedecker to guide them from the netherworld of the curse to the Elysian fields of physical and mental health, with an assortment of gynecologic tidbits as well as exercises thrown in for good measure.

In these days of consumerism, self-help, and self-diagnosis (flavored with the greater compassion that some women demonstrate for other women) this "how-to" paperback arrives timely on the scene. Menstruation, menstrual cramps, and menstrual problems are explained in a lucid manner and a variety of appropriate treatments are described thoroughly. Ideally, the physician-author might have provided a little more therapeutic guidance to the lay reader for whom this work is intended rather than offer an array of choices that might confuse the inexperienced. For instance, codeine was not suggested as a last resort but seemed to be given equal time and space with such effective remedies as oral contraceptives and antiprostaglandins. However, this minor criticism should not dissuade the physician from recommending this book to patients with menstrual problems.

Jerome Abrams, M.D.

Medical Thinking: A Historical Preface

Lester S. King, M.D. Princeton, NJ, Princeton University Press, 1982. Pp. 336. ($19.50)

According to Lester S. King, M.D., formerly the senior editor of *JAMA*, the technological advances of modern medical science really are new ways of answering old questions, yet the basic mode of medical thinking has not changed over the centuries.

"The medical texts of the 16th and 17th centuries and even until the 18th were long and rambling . . . filled with harmless speculations," he quotes from a modern critic—but within the ramble, one is fascinated by the philosophical approaches to the nature of health and disease, classification, and probable causal relationships.

Of what value is medical history? How many of our students entering medical studies today have heard the term consumption associated with tuberculosis and why? Dr. King admirably begins his thesis by using the case of tuberculosis to build and illustrate the example of historical background and development to determine causality and therapeutics as we know of it.

In the Galenic period, medicine was separated into theory and practice. The theory consisted of the segments of physiology, pathology, hygiene, and therapeutics—all of which were acquired empirically at that time. This remained unchanged through the 18th century. Thereafter, each segment evolved into separate specialties with further divisions, again by guesswork. For example, pathology dealt with diseases, causes, and symptoms—either with botanicals, herbs, or physical forces.

Vesalius, in 1543, made the major break by setting aside the previous guesswork—to learn for himself by anatomical dissection what was the truth. It was the beginning of pragmatic learning. Chemistry began its scientific methods in the early 18th century.

Laennec invented the first crude stethoscope by 1816; Pasteur had not yet been born to advise on the germ theory; Lister first used his therapeutic carbolic spray to combat sepsis by 1867; Koch did his experiments with tuberculosis in 1877 and published his first papers on the illness in 1882, just 100 years ago!

Fleming had not yet left his culture dishes accidently exposed to catch the mold that would revolutionize therapeutics until the second decade of the 20th century.

The Flexner report of 1910 would mark the division between good and bad medical education, training, and practice. No longer could guesswork or empirically acquired knowledge hold a place against scientific reasoning and methods; even the LMD of pre-World War II years had archeological knowledge of medicine compared to the student who started his work by 1945 and thereafter. Continued medical education was not prescribed as it is today.

I found Dr. King's book delightful in giving insight and perspective to the lines of thought that linked the generations of clinicians one to the other, and thence to the great minds of medical thought of today. The book is not a textbook, not a CME course. It is relaxing and commendable.

Finally, we are taught to remember above all: to know what we don't know, act as if we do, and limp along until we really know the truth. All truths will be known—someday.

Harry M. Poppick, M.D.

The Merck Manual. Volume 1. General Medicine.

Robert Berkow, M.D., (ed-in-chief). Rahway, NJ, Merck & Co., Inc., 1982. Pp. 1525.

The publishers and editors of this manual claim that the first edition was published in 1899. It seems, though, from the length of time it has been around that the physician-author of the Ebers papyrus had a copy at his elbow and old Hippocrates himself must have kept a copy at his clinic at Cos.

The fourteenth edition of this medical friend has just been published and it is better than ever.

It would be futile for this reviewer to attempt to describe the contents of *The Merck Manual*. Suffice to say that the whole of internal medicine is included here. The articles are not as expansive nor complete as those in the standard texts but each topic is covered more than adequately, concisely, and to the point.

The print is easily legible, the paper of good quality, and the binding quite secure. I would recommend *The Merck Manual* to all internists, general practitioners, medical students, and house staff.

I have one minor quibble: The book is supposed to fit into a jacket pocket. With dimensions of 13.5 x 21.5 x 4 cm and weighing 910.5 gm, it did not fit into

the pocket of any jacket that I own. Buy it anyway.

Leo Lewin, M.D.

The Merck Manual, Volume 2. Obstetrics, Gynecology, Pediatrics, Genetics. 14th Edition.

Robert Berkow, M.D., (ed). Rahway, NJ, Merck & Co., Inc., 1982. Pp. 476.

The Merck Manual, First Edition appeared in 1899. It was designed for general practitioners in selecting medications. Today, *The Merck Manual* is claimed by the publishers to be the most widely used medical text in the world, with the primary purpose of providing information to medical students and house officers.

The purpose of *The Merck Manual* is very ambitious. It covers general medicine and related specialty subjects, gynecology, obstetrics, pediatrics, and genetics. The 14th Edition is available in a single volume, and in pocket size of two smaller volumes; this volume is limited to gynecology, obstetrics, pediatrics, and genetics.

The editors, in the foreword to the book, ask the question: "Can so many subjects be covered adequately in a single book? You, the reader, must make the ultimate judgment, but we believe the answer is affirmative." After reviewing gynecology, obstetrics, and genetics in this volume, the answer is no. However, for the pediatrics section, the answer is yes.

Although I sympathize with the authors, the amount of information currently available in gynecology-obstetrics-genetics cannot be covered reasonably in 100 pages without sacrificing a great deal of vital information, especially if the book is marketed for worldwide use, as claimed by the publishers.

The information provided is so minimal in some instances, that the publication resembles a medical dictionary, rather than a summarized textbook. In addition, important information has been omitted entirely on some subjects, such as: a failure at least to mention thermography and ultrasonography evaluation of breast disease; the use of the vacuum extractor as an alternative to forceps in delivery; the use of prostaglandins in the management of missed abortion; and, the place and indication of electronic maternal-fetal monitoring in the obstetrical patient.

In the chapter discussing abnormalities and complications of labor and delivery, three major omissions are present: prolapse of the umbilical cord, premature rupture of membranes, and amniotic fluid embolism. When discussing the treatment of a spontaneous abortion, the term D&C (dilatation and curettage) is wrongly used; the correct terminology is E&C (evacuation and curettage).

The chapter related to pediatrics is presented in 300 pages, and is more successful.

Although comparisons usually are in poor taste, at the present time, most of the handbooks covering gynecology-obstetrics-genetics and pediatrics offer the reader much more complete and effective coverage of the subjects discussed in *The Merck Manual*.

I feel that several aspects of gynecological, obstetrical, and genetic problems of general interest to the medical student and house officer have been severely condensed or omitted, resulting in an oversimplification and dogmatism of the material presented.

Marco A. Pelosi, M.D.

Physical Education and Sport: An Introduction

Earle F. Zeigler, Ph.D. Philadelphia, PA, Lea & Febiger, 1982. Pp. 303. Illustrated. ($19.50)

Physical Education and Sport: An Introduction is intended for college level students who are studying physical education or for a general introduction to the field as part of a broad liberal arts program.

The book includes a philosophic review of the field and includes chapters on the history and development of the discipline, its relevance to social issues, and its future status. Chapters on the physiology of exercise, motor learning and development, anatomy and mechanical function of the body, management program development, measurements of function, and a brief mention of sports medicine are included.

It would be of some peripheral interest to a physician in sports medicine, but probably not to others.

Christine E. Haycock, M.D.

Problems in General Surgery

Jack Pickleman, M.D. New York, NY, Plenum Medical Book Co., 1982. Pp. 363. Illustrated. ($39.50)

This volume's purpose is to present surgically oriented problems in a multiple-choice format, with answers, explanations, and appropriate references; included are controversial areas, and subjects likely to be encountered in clinical surgical practice.

The innovative format is divided into 12 broad categories: esophagus, peptic ulcer disease, portal hypertension, pancreatico-biliary problems, bowel obstruction, inflammatory bowel disease, gastrointestinal cancer, endocrine surgery, breast, postoperative complications, thromboembolic disease, and trauma.

Under each title, the most commonly encountered problems are presented, based on the author's practice and experience, in self-assessment, home-study style. Following a multiple-choice answer to the posed clinical problem, an erudite discussion of the problem is presented, and the answer given. The language used is familiar to the surgical specialist primarily, so that a great deal of the problem discussion will be too technical for the general internist or family physician.

Joseph Peyser, M.D.

Review of General Internal Medicine. A Self-Assessment Manual. 2nd Edition

Lloyd H. Smith, Jr., M.D., and James B. Wyngaarden, M.D., (eds). Philadelphia, PA, W.B. Saunders Co., 1982. Pp. 326. Illustrated. ($19.50)

This book is designed to provide a comprehensive review of internal medicine in the form of a self-assessment examination. The format enables you to answer the questions, to determine which ones are right or wrong, and then to review those questions you answered incorrectly. The reference for most of the discussions is *Cecil's Textbook of Medicine. 16th Edition,* now edited by the same authors of this review.

For what purpose is such a book? Self-assessment and review for examination preparation would be a primary reason. There are many ways in which to learn medicine. Each student or physician will differ in the methods by which he or she learns most easily and effectively. The manual has been developed as a series of questions that test both knowledge and the ability to utilize it effectively in clinical medicine. Answers are supplied with rational explanations. The book has been designed primarily for continuing education of medical students, house staff, internists, family physicians, and especially those preparing for certification or recertification by the American Board of Internal Medicine.

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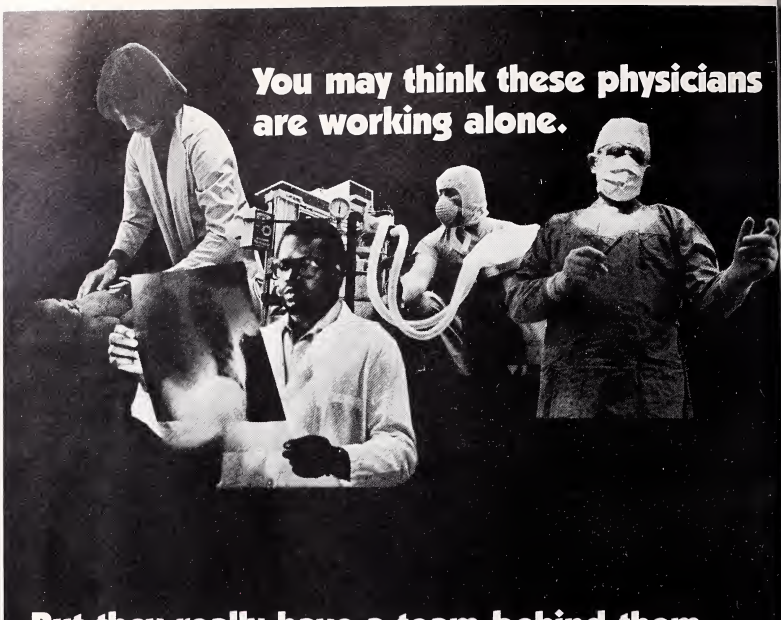
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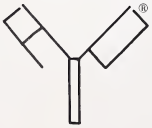
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2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis.* New York, NY, McGraw-Hill, 1969, Pp. 00-00.

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All communications should be sent to the Editor, *The Journal,* MSNJ, 2 Princess Rd., Lawrenceville, NJ 08648.

Your Angina patients could fly coast to coast on the long-acting effects of one 10mg tablet.

oavailability findings* of Oral, Sublingual and Chewable Cardilate® dosage forms in lunteers demonstrated that the Oral (swallowed) 10mg Tablet provided a 6-hour dura-n of pharmacologic effect; more than 3 times longer than when given sublingually, or the chewable Tablet. Cardilate Oral Tablets are recommended for the prophylaxis and ng-term treatment of patients with frequent or recurrent anginal pain and reduced ercise tolerance associated with gina pectoris.

nemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. Digital Plethysmography For Assessing Erythrityl Tetra-ate Bioavailability. Clin Pharmacol and Ther 29:35-39, 1981.

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ATIONS: Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent urrent anginal pain and reduced exercise tolerance associated with angina pectoris rather than for the treatment of the attack of angina pectoris since its onset is somewhat slower than that of nitroglycerin.

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NINGS: The use of nitrates in acute myocardial infarction or congestive heart failure should be undertaken only dose clinical observation and / or in conjunction with hemodynamic monitoring.

AUTIONS: Use with caution in patients with severe liver or renal disease. Tolerance to this drug, and tolerance to other nitrates, may occur. Cardilate should be given to a pregnant woman only if clearly ed. Caution should be exercised when Cardilate is administered to a nursing woman. Safety and veness in children have not been established.

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GE AND ADMINISTRATION: Oral / Sublingual : Cardilate (Erythrityl Tetranitrate) may be ad-ered either sublingually or orally. Therapy may uated with 10 mg. prior to each anticipated al or emotional stress and at bedtime ients subject to nocturnal at-The dose may be increased reased as needed.

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Each tablet contains acetaminophen and codeine phosphate* as follows:
acetaminophen, 325 mg and codeine phosphate*, 15 mg (¼ gr)
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*WARNING: May be habit forming.

Please see adjacent page for brief summary of prescribing information.

TABLETS

ANACIN-3®

ACETAMINOPHEN

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Brief Summary *(For full prescribing information see package insert.)*

Description: Each Tablet Contains:
Acetaminophen 325 mg, and Codeine Phosphate*, 15 mg
Acetaminophen 300 mg, and Codeine Phosphate*, 30 mg
Acetaminophen 300 mg, and Codeine Phosphate*, 60 mg
*WARNING: May be habit forming.

Contraindications: Hypersensitivity to acetaminophen or codeine.

Warnings: Drug Dependence: Codeine can produce drug dependence of the morphine type, and may be abused. Dependence and tolerance may develop upon repeated administration. Prescribe and administer with the same degree of caution appropriate to the use of other oral narcotic medications. Subject to the Federal Controlled Substances Act (Schedule III).

Precautions: *Head injury and increased intracranial pressure.* The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions. Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients: Administer with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Information for Patients: Codeine may impair the mental and or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient taking this drug should be cautioned accordingly.

Drug-Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety, or other CNS depressants (including alcohol) concomitantly with acetaminophen and codeine may exhibit additive CNS depression due to the codeine component. When such therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with codeine preparations may increase the effect of either the antidepressant or codeine.

The concurrent use of anticholinergics with codeine may produce paralytic ileus.

Usage in Pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, acetaminophen and codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Nursing Mothers: It is not known whether the components of this drug are excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when acetaminophen and codeine are administered to a nursing woman.

Adverse Reactions: Most frequently: Lightheadedness, dizziness, sedation, shortness of breath, nausea and vomiting. More prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Others: Euphoria, dysphoria, constipation and pruritus.

Dosage and Administration: Dosage should be adjusted according to severity of pain and response of the patient. However, it should be kept in mind that tolerance to codeine can develop with continued use and that the incidence of untoward effects is dose related. This product is inappropriate even in high doses for severe or intractable pain. Adult doses of codeine higher than 60 mg fail to give commensurate relief of pain but merely prolong analgesia and are associated with an appreciably increased incidence of undesirable side effects. Equivalently high doses in children would have similar effects.

Adults: **Codeine**—15-30 mg (for mild to moderate pain)
60 mg (for moderate to moderately severe pain)
Acetaminophen—300-600 mg

Children: **Codeine**—500 mcg/kg

Doses can be repeated up to every 4 hours.

Full directions for use should be consulted prior to administering or prescribing.

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Statute of Limitations, Controlled Substances, and Informed Consent

A minor's action for alleged negligence in her mother's prenatal and postnatal care was not barred by the statute of limitations, a federal court ruled.

The minor brought an action against the hospital where she was born and a physician, contending that the physician administered an excessive dose of Carbocaine® to her mother, affecting her respiratory ability at birth. The resultant lack of oxygen flow to her brain caused her to be mentally retarded. She also contended that the physician and hospital employees were negligent in not adequately resuscitating her after birth.

The physician and hospital moved for summary judgment on the grounds that the suit, which was filed more than 13 years after the alleged negligent acts, was barred by the statute of limitations. The court granted the motion.

On appeal, the minor relied on a provision of state law governing actions by infants and allowing her to bring suit within two years after her disability was removed. Finding that the provision tolled the statute of limitations, the court ruled that she could bring the action at any time before she reached the age of 20 or within two years thereafter. The court reversed the lower court's judgment and sent the case back for further proceedings (Hatfield v. Bishop Clarkson Memorial Hospital, 679 F.2d 1258. C.A. 8, Neb., June 17, 1982. Citation, Vol. 46, No. 4).

New Jersey Statute 2A:14-21 governs the time period in which legal actions must be filed by a minor. It permits the filing of a personal injury lawsuit within two years after the minor reaches age 21.

This statute enlarges the permissible time interval between the occurrence and the filing of a lawsuit for the minor only. It does not extend the time period for the minor's parents.

Physicians should maintain and store the medical records of their patients who are minors in accordance with this extraordinary provision of the law.

CONTROLLED SUBSTANCES: STORAGE, RECORDKEEPING, AND DISPOSAL REQUIREMENTS

A New Jersey physician has asked the Department of Liability about the storage, recordkeeping, and disposal requirements of controlled dangerous substances.

Various provisions of the New Jersey Administrative Code govern the physician's responsibilities in this area.

New Jersey Administrative Code, Title 8, Section 8.65-2.5 requires physicians to store all controlled substances in a securely locked, substantially constructed cabinet. If theft or significant loss of any controlled substance occurs, physicians must notify the regional office of the Bureau of Narcotics and Dangerous Drugs, Department of Justice, or the New Jersey State Department of Health, Drug Control Program upon discovery of such loss or theft.

Section 3.65-5.3(b) requires that physicians keep records only with respect to controlled substances listed in schedules II through V, which the physician dispenses other than by prescribing or administering. Thus, where the physician writes a prescription to be filled by a pharmacist for a controlled substance, or directly administers the substance to the patient via ingestion, injection, or infusion, no recordkeeping other than the patient's record is required. However, where the physician provides the patient with the drug sample to be used according to the physician's directions, a separate record must be kept of the drug and the amount dispensed to the patient.

Section 8.65-5.3(c) provides the recordkeeping requirement for nonnarcotic controlled substances. Where the physician dispenses in any manner any nonnarcotic substance listed in schedules II through V, without a charge to the patient for such dispensing, no record other than the patient's medical record is required. However, where the physician regularly charges his patient for this service, no matter whether the charge is separate from charges for other professional services or is included with charges for other professional services, a separate record noting the drug and the amount dispensed to the patient must be made.

In addition, Section 8.65-5.6 and 5.7 requires physicians to maintain a biennial inventory of controlled substances. The inventory must be maintained in a written, typewritten, or printed form. An inventory taken by use of an oral recording device must be transcribed promptly. Section 8.65-5.4 requires schedule II substances to be listed separately from all other records; substances listed in schedules III, IV, and V must be maintained either separately from all other records or in such a form that the information readily is retrievable from the physician's ordinary business records.

Unwanted scheduled substances should not be merely discarded by the physician. Section 8.65-8.9 provides the procedure for disposing of controlled substances. Physicians are advised to seek the assistance of Mr. Lucius Bowser, Chief, Drug Control Program, New Jersey Department of Health, regarding instructions for disposal and reporting requirements. Mr. Bowser may be reached at 609-984-1312.

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Director of Special Projects.

We take this opportunity to further advise you of the recent rescheduling of the drug methaqualone. Methaqualone now is listed as a schedule I controlled dangerous substance (see New Jersey Administration Code 8.65-10.1 and 10.2 as amended). Schedule I substances are those which the Commissioner of Health has found have a high potential for abuse and have no accepted medical use in treatment in the United States, or lack accepted safety for use in treatment under medical supervision. Physicians should arrange for return of this substance to the supplier, or dispose of it in accordance with section 8.65-8.9.

PRESIDENT'S COMMISSION UNDERSCORES FLAWS IN INFORMED CONSENT PROCESS

Even with marked emphasis upon the process of obtaining informed consent from patients for diagnostic and therapeutic procedures today, the medical and hospital communities evidently still have a long way to go to improve results in this suit-generating area.

A survey recently released by the President's Commission on Ethics in Medicine and Research reveals what is termed a "credibility gap" between what doctors say they tell their patients and what patients say they hear. Drawing upon data obtained in national surveys of representative samples of physicians and the public, conducted by Louis Harris and Associates, as well as observations of actual consent obtaining procedures, the Commission concluded that the public needs more education and that the process of obtaining truly informed consent must be fine-tuned.

One problem, said the Commission, is that consent forms usually are preprinted and handed to patients just prior to performance of a diagnostic or therapeutic procedure. The information all may be there regarding the contemplated procedure, the risks, alternatives, and probable outcome, but for a lot of reasons, the patient may not truly "hear" or "understand," even though he or she says so and signs the form.

The Commission said that to be effective, informed consent must be a shared decision-making process involving mutual respect and understanding between a physician and a patient, not merely the process of executing a signed legal document.

According to the study, four out of five Americans now believe that the procuring of a signed consent form is merely a legal maneuver by which physicians and hospitals protect themselves from possible lawsuits. This finding is "dismal and startling," said Morris B. Abrams, chairman of the Commission which is composed of medical, legal, public affairs, and religious community representatives.

The Commission warned against withholding possible "bad news" from patients—risks and adverse outcomes—even though physicians sometimes try to do so out of a sense of paternalism for their patients or to encourage cooperation with their treatment. Actually, according to the study, patients more often refuse treatment when information is withheld than when the full picture is presented to them.

Patients are entitled to full and adequate information as a prerequisite to performance of medical and surgical procedures, the Commission emphasized. It said that probably the greatest improvement would come in the process only if physicians and nurses were trained in the necessary steps during their education. *Medical Liability Monitor,* Vol. 7, No. 11, November 29, 1982.

DID YOU KNOW . . .

The U.S. Department of Justice may file a restraint of trade suit against Miami area doctors who boycotted nonemergency surgery last June, protesting increases in malpractice insurance rates? Donald Book, an attorney for doctors in Dade and Broward counties, says the Department is taking depositions from doctors involved in the boycott and demanding hospital records. Book believes the Justice Department could be trying to intimidate the doctors into signing an agreement not to boycott in the future. *Medical Economics,* December 6, 1982.

At a recent ABA litigation meeting in Chicago, Philip H. Corboy, a famed Chicago malpractice lawyer, stated, "Negligence measured by professional standards, supplied for the most part by the medical profession itself, is what we are talking about, such as inattentiveness on a singular occasion, a generalized failure in or of training, and the simple inability to handle a given particular problem?" *American Medical News,* December 3, 1982.

$29 MILLION DOLLAR AWARD

The sum of $29,220,000 in damages against St. John's Episcopal Hospital, Brooklyn, New York, was awarded by a jury in New York Supreme Court on October 1, 1982. This award may be the largest ever in a personal injury suit, according to the attorney for the plaintiffs, Fred Peters of the Brooklyn firm of Peters, Berger & Koshel.

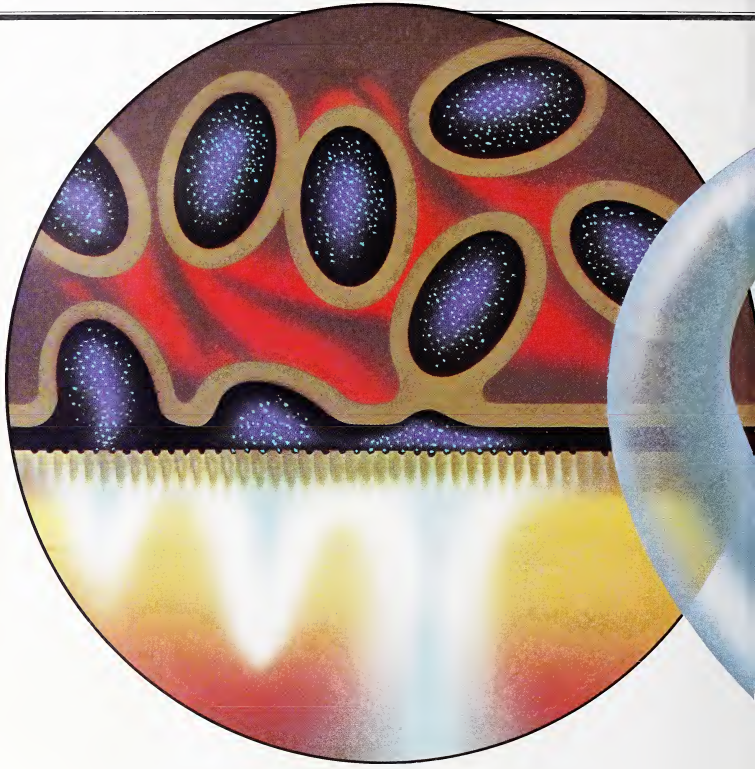
Early in 1978, the parents of six-month-old Muriel Marcelin brought the child to a hospital pediatrician who diagnosed her problem as a common cold and prescribed cough medicine. Eight days later, she was admitted with severe cerebral meningitis which left her paralyzed and blind. The jury calculated the award on the basis of an expected 55-year lifespan for the 5-year-old. She requires constant, costly care. If the huge award is upheld, it will be paid in one lump sum; the lawyer's fee, if approved, will constitute one-third of the award, or nearly $10 million. Peters is a member of the Inner Circle of Advocates, trial lawyers who have tried at least 50 cases to verdict and won at least one $1 million or more award. *Medical Liability Monitor,* Vol. 7, No. 11, November 29, 1982.

PARENTS RECOVER FROM NEGLIGENT VASECTOMY

The Appellate Court of Florida recently ruled that in a case of a negligent vasectomy, resulting in the birth of a child with substantial physical and mental defects, the parents are entitled to recover for special medical and educational expenses of the child to age 18.

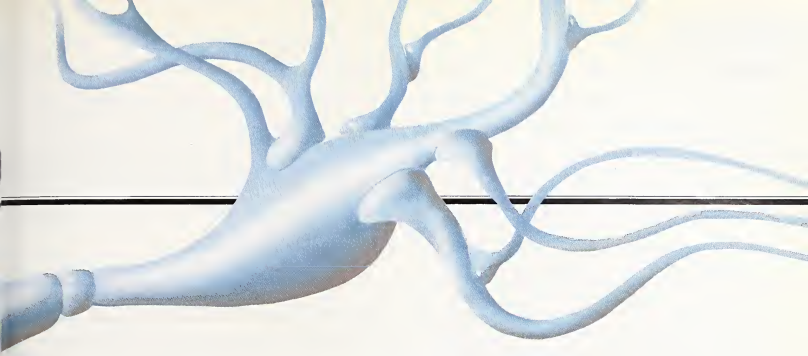
The Court wrote: "This exception . . . is based on the premise that the parents in cases of this nature have been damaged, in part, by the rearing of a child born with substantial mental or physical defects. True, such a child is still the child of the parents, not the physician, and ordinarily should be supported by the parents. Still, the special medical and education expenses, beyond normal rearing costs, associated with raising such a child often are staggering, creating great financial drain upon the parents . . . Under the circumstances, then it is thought not altogether unfair to require the physician to bear the special medical and educational expenses of raising a child to majority, over and above normal rearing costs." *Personal Injury Newsletter,* Vol. 26, No. 10, November 8, 1982.

VALIUM® (diazepam/Roche) IN THE FOREFRONT OF NEURORECEPTOR RESEARCH



Artist's concept of neurotransmitter being released into synaptic cleft and impinging on receptor sites

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Opening new investigative pathways into where and how Valium (diazepam/Roche) exerts its distinctive antianxiety action

New discoveries in receptor research have stimulated the search for endogenous brain substances that may be involved in the mediation of anxiety.[1-5] It has been further theorized that these substances may act as ligands that bind to the same or similar sites as do benzodiazepine molecules[5,6]—binding sites early identified with the use of ^{3}H-diazepam.[5,7] These binding sites are now postulated to be benzodiazepine receptors, since the ability of benzodiazepines to bind with the sites appears to correlate with their clinical effects.[2,4,7,8]

Present investigations into clinical relevance of binding sites. Laboratories at Roche have conducted research to identify and isolate substances that may prove to be endogenous ligands, but no definitive identification has yet been made. Researchers are also studying substances which do not bind, but rather interact with the benzodiazepine binding sites—most notably gamma-aminobutyric acid (GABA)—and are postulated to mediate certain pharmacologic and clinical benzodiazepine effects.[2-4,9,10]

Under especially intense investigations are the GABA receptors and the benzodiazepine binding sites themselves—apparently constellations of closely linked but not identical structures.[8]

Future implications for improved therapy. In future work, Roche researchers and other scientists hope to identify and characterize various differential sites in the brain, which may result in more specific diagnostic and therapeutic approaches.

2-mg, 5-mg, 10-mg scored tablets

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THE RESEARCH AND CLINICAL LEADER

Please see brief summary of product information and references on the following page.

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VALIUM® IV
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not as sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500.* Prescription Paks of 50, available in trays of 10.† Tel-E-Dose* packages of 100, available in trays of 4 reverse-numbered boxes of 25† and in boxes containing 10 strips of 10.†

*Supplied by Roche Products Inc., Manati, Puerto Rico 00701
†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110

References: 1. Taliman JF *et al: Science 207*:274-281, Jan 18, 1980. 2. Bunney WE Jr: *Psychiatr Ann 11*:11-15, Jan 1981. 3. Davis JM *et al: J Clin Psychiatry 42*(11) Sec 2:4-14, Nov 1981. 4. Study RE, Barker JL: *JAMA 247*: 2147-2151, Apr 16, 1982. 5. Braestrup C, Nielsen M, Olsen CE: *Proc Natl Acad Sci USA 77*:2288-2292, Apr 1980. 6. Bosmann HB, Case KR, DiStefano P: *FEBS Lett 82*:368-372, Oct 1977. 7. Braestrup C., Albrechtsen R, Squires RF: *Nature 269*:702-704, Oct 20, 1977. 8. Snyder SH: *Psychosomatics 22*:986-989, Nov 1981. 9. Rickels K: *J Clin Psychiatry 42*(11) Sec 2:40-44, Nov 1981. 10. Haefely WE: *Br J Psychiatry 133*:231-238, Sep 1978.

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TAXING THOUGHTS

By Mark Carter Trentacoste, MBA, J.D.

Tax Traps in Leasing

Especially when individual income tax rates were as high as 70%, professionals found it extremely attractive to personally purchase equipment and other property and lease the property to their corporations. Even with combined federal and state tax rates now about the same for individuals and corporations, leasing may still be advisable for shifting income and other reasons.

However, leasing can easily become an expensive tax trap for the unwary. Depending on the length of the lease and the expenses which the lessor pays under the lease, the professional acting as a lessor may not be eligible for investment tax credit on the leased property. The lease must be carefully drafted to assure that the lessor will be entitled to the credit. An informal lease will almost certainly cause the I.R.S. to deny the credit to the lessor.

Often, however, the professional is better advised to file the necessary election to allow the lessee to claim the investment tax credit. If the lessor claims the credit and then finds it disallowed on audit it will be completely lost—the lessee will not be able to claim it.

Now that the interest rate I.R.S. can collect on tax deficiencies is well above market rates, falling into a tax trap can be an especially painful experience.

(Mr. Trentacoste formerly practiced as a CPA and is now an attorney with a general commercial practice. He welcomes the opportunity to discuss this or other issues informally or as part of a professional consultation.)

Mark Carter Trentacoste, Esq.
Old Town Hall, Suite 6

Moorestown, N.J.
Phone 234-5144

The Annual Meeting

Physicians are indeed individuals—not products of a cookie-cutter—made from a nonduplicative genetic templet. "Mind of his/her own" is an underdescription of the medical doctor's mentation. One vote is a trifle and a single voice has trouble being heard in the halls of justice (or injustice), the houses of state and federal government, and the bureaucratic nooks and crannies where policies affecting us all are interpreted, sometimes distorted, and inevitably implemented.

What has this to do with April 29, 1983, to May 2, 1983? A whole bunch!

The Annual Meeting of the Medical Society of New Jersey consists of a number of elements:

1. Board of Trustees meetings.
2. Reference Committee meetings.
3. House of Delegates business sessions.
4. Scientific and informational lectures and exhibits.
5. Social affairs and awards ceremonies.
6. JEMPAC political forum.

It is not all sweat and toil with the "slots" and gaming tables nearby—but business is the major order of the days.

It goes without saying that the trustees and the officers, delegates, and committee members will be there. Will you?

If you are not concerned about the practice of medicine in all its pluralistic forms, do not come. If you are content with government health policies, stay away. If you do not feel threatened by the litigious public, go fishing. If the actions of the State Board of Medical Examiners do not intimidate you and the security of your license, visit Greece. If the attempted infringements of auxiliary health workers into the physician's traditional professional turf leave you cold, hop off to the Caribbean and warm up. If Medicare, Medicaid, Blue Shield, and HMOs are of no interest to you, fly to Mexico.

But if any of these issues and a lot more do concern you, you had better come to the Annual Meeting and put your three cents in.

The physician, through county and state medical societies, can be heard and can make waves at the Annual Meeting. Members are welcome at open meetings of the Board of Trustees and are privileged to question and comment. It is your duty to yourself to attend the Reference Committees, to speak up and inform the members of your interpretations, and to register your vote on those critical issues that the House of Delegates will debate and decide for all of us. Buttonhole your officers, trustees, or delegates in the corridors of Resorts International or at your county medical society hospitality suite and give them a piece of your mind.

The Medical Society of New Jersey is a grand self-help organization. If you think you can do it alone, you are misguided. If you assume your leaders and representatives can read your mind, they can't.

Don't be a political recluse—come down, speak out, and pound a few tables with your fist or your shoe. Try it, you'll like it.

What? 217th Annual Meeting.
When? April 29, 1983, to May 2, 1983
Where? Resorts International, Atlantic City. A.K.

Retrospective

Ten years ago, Arthur Krosnick, M.D., joined the staff of *The Journal*. And *The Journal* has been enriched handsomely by his participation and guidance.

Looking over the 120 issues that Dr. Krosnick has edited, we found an exciting collection of still-pertinent editorials. We decided that a reprinting of a few of his editorials would honor the tenth anniversary of his appointment as Editor.

The following is a small sampling of the material Arthur Krosnick, M.D., has penned over the years; these perceptive editorials give us a chance to review and reconsider the confrontations, confusions, and changes that affect the medical profession.

STAY ON YOUR PEDESTAL
JULY, 1974

Individual physicians and organized medicine alike have an awesome responsibility to maintain patient and public trust which began more than two millennia ago. While doing their jobs in personal and public health and in medical education, physicians have commitments to their patients and communities and to their hospitals and medical colleagues. They are indebted to the teachers and responsible for their students. Not to be forgotten is a dedication to family and friends, and, with all this, self is often overlooked.

It takes a good deal of strength, courage, and devotion to maintain one's equilibrium under such circumstances. Despite the pressures, each physician must be careful not to fall off the invisible pedestal on which public opinion continues to maintain him.

SYMBOL OF AUTHORITY
FEBRUARY, 1975

Two decades ago, the famous radio, television, and film comedian, Ernie Kovacs, starred in a television drama, "Symbol of Authority." Kovacs played the role of an introverted, reclusive bookworm-type person. In his job as a proofreader in a medical publishing company, he became familiar with scientific terminology and the language of medicine.

One day, while enroute to work, he found a stethoscope

lying in front of a large city hospital. He retrieved the lost instrument and started to enter the hospital to return it when a startling thing happened. As he reached the door, a doorman flung open the hospital door with a flourish and a bright, "Good morning, doctor." With stethoscope in hand, the same thing happened in the corridor and in the elevator.

Needless to say, he kept the stethoscope and began to visit the hospital daily at lunch time. One day, he was stopped by an elderly female patient who wanted to ask the doctor some questions but was repeatedly frustrated because he was "always too busy." Kovacs the character listened intently but never offered medical advice. He "made rounds" daily and developed a delightful relationship with the old lady.

As one might guess, the imposter was caught, charged with practicing medicine without a license, and hauled before a judge. In a moving self-defense, Kovacs the character stated that he never intended to hurt anybody, and that he never did anything but listen to the patient and offer sympathy and understanding.

The questions raised by this poignant playlet have timeless significance. Are we physicians too busy to listen, to show compassion, and to offer solace and comfort that patients expect and deserve? Are we fully aware of the power that resides in the stethoscope as a symbol?

This may be more notable when the art of medicine is being crowded by the science of medicine—dependence on the mechanical diagnostic and therapeutic techniques, which add immeasurably to our acumen but steal our time. It may take two hours to perform and interpret selective arteriography, but only a few seconds to tell a patient that he has an aneurysm. How much time should be elicited to soften the blow and prepare the patient?

It appears that the art of medicine—and the stethoscope—merit a little more of our attention—and so do our patients.

BIG TRUTH VERSUS BIG LIE
OCTOBER, 1977

It is essential for New Jersey physicians and American medicine to combat the big lie with the big truth. The facts are:

1. American medicine is the best in the world if one takes into account all the statistics of morbidity and mortality, the safety and efficacy of drug research, the development and application of new therapeutic methodology through careful research, accessibility to the health care system, the training of physicians and other professionals, and all the other elements of the system.

2. The high cost of health care in the United States is due to increased hospital bed utilization and intrinsic hospital costs due to the application of new expensive methods and equipment developed through scientific advancement. Other factors of significance are inflation and the considerable financial burden of government regulations.

3. The track record of government regulation in space research, energy research, the postal system, and so on, with blunders, cost over-runs, and pure waste is so bad that one cannot believe that total government control of the health care system will be anything but a financial disaster.

4. It is a virtual impossibility for government to place stifling cost controls on the health care system without some deterioration in the quality of health care. The fact is that introduction of such a system results in so-called health priorities that inevitably exclude many major benefits including health education and disease detection and which result in inordinate waiting periods for hospital admission and consultations with specialists and the like. Second-rate treatment and diagnosis and treatment must result.

5. The nature and temperament of the American public is such that it will not tolerate a system like the one which exists in the United Kingdom. The dissatisfaction with delays, the layer upon layer of regulations, and the restrictions of self-determination would produce an explosive reaction.

THERAPEUTICS OVER A QUARTER OF A MILLENIUM
SEPTEMBER, 1979

If a modern physician were asked some principles of health and lifestyle which would prevent or cure many—if not most—of man's ailments, he might include the following:

1. Eat a simple and easy-to-digest diet that includes salts and condiments in limited amounts.

2. Avoid or sharply limit the intake of strong alcoholic beverages.

3. Regular exercise is necessary and walking is the best exercise.

4. Exercise is best on an empty stomach and should never cause exhaustion.

5. Coffee and tea consumption should be limited by tense individuals.

6. Have faith in God.

7. Get a full night's sleep daily.

8. Emotional tension should be prevented or controlled or your medication won't work.

9. Take your medications as prescribed.

This remarkably apt list was drawn from experience, ancient teaching, and intuition, rather than scientific investigation. It is included in the preface of a book written by Dr. John Wesley in 1747.

Despite all the scientific advance we have made, physicians may need to throw in a little security blanket as did Wesley:

10. Above all, add to the rest (for it is not labour lost) that old fashionable medicine, prayer."

PATIENT HEALTH EDUCATION
SEPTEMBER, 1982

What can be done for prevention, self-management, and cost-containment through patient education? There are a number of options to be considered:

1. Organized outpatient education programs should be developed by responsible health agencies in accordance with available guidelines as the qualifications of the educators and as to the content of the curriculum and the duration and process of the educational experience.

2. All third-party payers should be made aware of the existence of and the potential benefits to their overall fiscal picture from standardized patient education programs.

3. Such programs should be developed on a fee-for-service basis.

4. They should be located at convenient sites (hospitals, free-standing HMOs, health departments, visiting nurse offices, and other health agencies).

5. Times of educational programs should be convenient to all consumers who need the training so they will have the opportunity to obtain it.

CONCLUSION

With this, we salute Dr. Krosnick and wish him well for at least ten more years with *The Journal*. And, if you have the time, pick up a couple of old copies of *The Journal* and read a few more of the editorials penned by our Editor.

G.H.

Hospital Corporate Reorganizations and Their Impact on the Private Practice of Medicine

The new corporate structures being utilized by hospitals are designed to segregate the "regulated" areas from activities with potential for profitable growth. Thus, the hospital is assured of funds to meet capital needs. This concept is touted by many hospital accountants as the only way to provide sound financial management and, consequently, avoid the risk of financial failure or being taken over by a more aggressive institution.

The November 4, 1982, issue of the *Medical Practice Letter* contains an interesting discussion in this regard. It states that the "idea is to generate a profit which can't be touched by Medicare (state) regulators who penalize the single corporation by offsetting income from new ventures against patient reimbursement." The new ventures to be engaged in are described as satellite clinics, billing and management services, practice consulting for private practices, direct medical services, health and social centers, senior citizen housing, adolescent centers, health hazard and risk appraisal, loss control, screening clinics in preventive and rehabilitative medicine, cardiology, and sports medicine. Peer review activity is to encompass health care evaluation while health education and promotion also are entertained. Quite a list!

The author of the article, however, has succeeded in piercing the corporate veil and revealing that hospital managers are designing corporate conglomerates, with diversified activities not necessarily related to the purposes for which hospitals originally were established. Such a course can have a devastating impact on the medical staff of the hospital and all other practitioners within that hospital's sphere of influence. The Medical Society of New Jersey clearly is concerned about these adverse consequences as is the AMA. Physicians are groping for a solution to this assault on their economic and professional independence.

The American Hospital Association (AHA) does not offer the physician community any solace in this regard. The AHA has been a prime advocate of the corporate restructuring concept and has promoted restructuring on an extensive regional basis. The general goals for reorganization were listed in the May-June, 1982, *Medical Staff Forum,* an AHA publication. They are:

- Protect income and assets from offset against reimbursement and taxation.
- Improve reimbursement for services allocated to noninpatient areas and affecting other payment methodologies and approaches.
- Protect their tax-exempt status and minimize unrelated business income tax.
- Improve overall profitability by diversifying revenues, maximizing reimbursement, and minimizing taxes.
- Improve access to capital by increasing the sources of capital that can be tapped.
- Raise capital through activities that are outside the control of regulatory agencies, such as financing medical offices.
- Provide more appropriate compensation arrangements for managers, for example, incentive plans that would not be permitted in tax-exempt organizations.

Reading these goals within the perspective of commercial enterprise is quite logical. It is distressing, however, to realize they are the avowed objectives of "nonprofit hospital corporations." The absence of a stated commitment to utilize the funds so diverted, sheltered, and nurtured for improved service and quality of care is frightening. The goal regarding compensation arrangements for managers raises a serious question about the motivation of persons being employed to manage hospitals. If they cannot be motivated adequately by the pursuit of excellence and a fair and comfortable salary, I doubt that anything reasonable ever will suffice.

I do not know how physicians and hospital trustees will resolve the inevitable conflicts that will occur within the market reach of the reorganized hospitals. They must, however, address the issue that there will be certain conflict as hospitals expand their corporate horizons. The rational means of dealing with these problems are to identify, analyze, discuss, and resolve. Hospital trustees and their medical staffs have an obligation to approach forthrightly these matters and to reach mutually acceptable positions, bearing in mind that true service to the community and the patients being treated within the hospital are the ultimate goals.

Failure to properly harness and channel hospital efforts can only produce a poor prognosis for the private practice of medicine. Justifying what is being done as the only available response to overregulated and misdirected government controls is fallacious. If the regulatory effort has produced a publicly unacceptable result, the solution lies in regulatory change. Unless the regulatory course is altered, it will in time simply identify the results of reorganization, and then adjust to negate their effect.

*The material for this column is coedited by Arthur Krosnick, M.D., Editor of *The Journal;* Vincent A. Maressa, Executive Director, MSNJ; and James E. George, M.D., J.D., Director of the Department of Professional Liability, MSNJ.

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BRIEF SUMMARY
PROCARDIA® CAPSULES For Oral Us
(nifedipine)

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for th management of vasospastic angina confirmed by any of the following criteria: 1) classical patte of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm pr voked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patien who have had angiography, the presence of significant fixed obstructive disease is not incompatib with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDI may also be used where the clinical presentation suggests a possible vasospastic component bi where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion in unstable angina where electrocardiographic findings are compatible with intermittent vasc spasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated t the management of chronic stable angina (effort-associated angina) without evidence of vasospas in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitra or who cannot tolerate these agents

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlli trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance but confirmation of sustained effectiveness and evaluation of long-term safety in those patients a incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA ar beta blocking agents may be beneficial in patients with chronic stable angina, but available infor mation is not sufficient to predict with confidence the effects of concurrent treatment, especially patients with compromised left ventricular function or cardiac conduction abnormalities. When in troducing such concomitant therapy, care must be taken to monitor blood pressure closely sin severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly to erated hypotension. These responses have usually occurred during initial titration or at the time subsequent upward dosage adjustment, and may be more likely in patients on concomitant bet blockers

Severe hypotension and/or increased fluid volume requirements have been reported in patient receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypas surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to b due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur wit PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcot analgesics cannot be ruled out

Increased Angina: Occasional patients have developed well documented increased frequency, du ration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mech anism of this response is not established but could result from decreased coronary perfusio associated with decreased diastolic pressure with increased heart rate, or from increased deman resulting from increased heart rate alone

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a with drawal syndrome with increased angina, probably related to increased sensitivity to catecho amines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expecte to exacerbate it by provoking reflex catecholamine release. There have been occasional reports o increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is importan to taper beta blockers if possible, rather than stopping them abruptly before beginnin PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed hea failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk fo such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular re sistance, careful monitoring of blood pressure during the initial administration and titratio of PROCARDIA is suggested. Close observation is especially recommended for patients alread taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vaso dilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated wit PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diureti therapy. With patients whose angina is complicated by congestive heart failure, care should be take to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experienc in over 1400 patients in a non-comparative clinical trial has shown that concomitant administratio of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasiona literature reports suggesting that the combination may increase the likelihood of congestive hear failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there hav been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelv normal volunteers. The average increase was 45%. Another investigator found no increase in di goxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not meas ured, digitalis toxicity was not observed. Since there have been isolated reports of patients wit elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjust ing, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nife dipine caused reduced fertility at a dose approximately 30 times the maximum recommended hu man dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity i rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of pa tients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antian ginal medication. Additionally, the following have been reported: muscle cramps, nervousness dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shaki ness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fe ver, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the nat ural history of the disease in these patients. It remains possible, however, that some or many o these events were drug related. Myocardial infarction occurred in about 4% of patients and conges tive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction distur bances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phos phatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly ele vated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladde disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy i uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069 2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the man ufacturer's original container.

More detailed professional information available on request.

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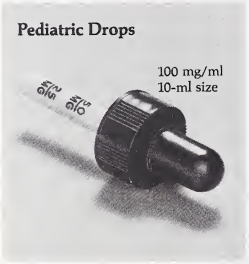
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Depression in the Elderly: Principles of Tricyclic Antidepressant Treatment

JAMES L. ELMORE, M.D., and
JOSEPH ROCHFORD, M.D., Belle Mead*

The role of pharmacodynamic and pharmacokinetic factors and plasma levels of tricyclic antidepressants (TADs) in the successful management of depression in the aged are discussed. Use of TAD plasma levels enables the physician to administer the lowest effective dose, ensure patient compliance, and avoid toxicity.

Depression affects a much higher proportion of the elderly than of the general population.[1] Tricyclic antidepressants (TADs) are prescribed most frequently for the treatment of major affective disorder (MAD) but can be very difficult to use in the elderly because of the prevalence of major medical illnesses and the high risk of serious adverse reactions. As a class, TADs have a low margin of safety between therapeutic and toxic doses and toxicity, even on standard doses, occurs more frequently in the elderly.[2] TADs are effective in approximately 65 percent of all patients with MAD,[3] but it is our impression that TADs are not as effective in the elderly. Although TADs were introduced over 25 years ago, the effectiveness, pharmacodynamics, and pharmacokinetics in the elderly have been investigated only partially. Understanding the alterations in the pharmacokinetics and pharmacodynamics of TADs brought on by the biological processes associated with aging can assist in preventing toxicity and increasing therapeutic effectiveness.

A major advance in the clinical treatment of elderly depressed patients with TADs has been the advent of techniques for monitoring plasma levels of TADs.[4] Therapeutic levels as well as toxic and subtherapeutic levels for some of these medications have been established.[5]

DIAGNOSIS

Because of the risks associated with TAD treatment, elderly patients with depressive symptoms should undergo a careful diagnostic assessment to determine if they have the type of depression likely to respond to TADs, i.e. MAD unipolar depression or bipolar disorder, depressed phase. The clinical symptoms of these disorders include a state of dysphoric mood characterized by depression, sadness, "blue feelings," hopelessness, and irritability plus at least four of the following symptoms for a period of at least two weeks: decreased or increased appetite; insomnia or hypersomnia; psychomotor retardation or agitation; loss of interest or pleasure in life; loss of energy or fatigue; feelings of worthlessness and guilt; complaints of diminished ability to think; and recurrent thoughts of death or suicide. There should be no mood-incongruent hallucinations or delusions, organic brain syndrome, or schizophrenia as a component of the symptom complex.

A medical examination including an electrocardiogram should be done prior to starting these medications. Further clarification of the diagnosis sometimes can be obtained by neuroendocrine studies such as the dexamethasone suppression test (DST) and the thyrotropin-releasing hormone thyroid-stimulating hormone test (TRH-TSH).[6,7]

PLASMA LEVELS

Ingestion of a given dose of a TAD results in a steady state

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plasma level generally within 7 to 21 days. There is minimal variation among individuals in the active free TAD fraction in plasma, but the elderly have less protein binding and a greater plasma free fraction and, thus, are susceptible to both the benefits and the noxious effects of the TADs.

The current procedure for measuring TAD levels is to stabilize the patient on a certain dosage of TAD for at least one week and then obtain a blood sample 8 to 12 hours after the last ingestion of the medication. The sample is collected in a Venoject® tube which is centrifuged at 2000 rpm for ten minutes and then the plasma is transferred to another tube and stored at −20°C.

Presently, most patients suffering from their first depressive illness are maintained on TADs for at least six months because of evidence that this may be the usual duration of a depressive episode. Patients with recurrent depressive illnesses may be maintained on TADs indefinitely to prevent relapse. These general guidelines must be supplemented by the physician's judgment of the clinical state of the patient. Recent investigations suggest additional information about the likelihood of recurrence of depressive illness can be gained by administering either the DST or TRH-TSH tests after the patient has been maintained on TADs for a number of months.[8,9]

Most reports on the relationship between plasma levels of TADs and clinical response were conducted over a two- to six-week period.[10,11] Loo et al. followed patients over a 3- to 26-month period with plasma TAD levels and found that large fluctuations in plasma TAD levels were associated with poor outcome.[12] They concluded that long-term plasma TAD level monitoring is warranted, especially in patients who fail to respond or have severe side effects.

One individual may have 30 times the plasma level of another on a given TAD dose, although variations of fivefold to tenfold are more common. This variability may be secondary to genetic factors or poor patient compliance. The plasma TAD level may be increased by concurrent administration of antipsychotic preparations, methylphenidate, and corticosteroids. Anticonvulsants, lithium, barbiturates, chloral hydrate, alcohol, birth control pills, and smoking are known to decrease TAD levels. Absorption of TAD is changed by antacids.

PHARMOKINETICS

The aged individual is more vulnerable to toxic effects and side effects of a variety of psychotropic agents. Pharmacokinetic factors, including drug absorption, distribution in body compartments, binding to plasma protein, metabolism, and excretion are major determinants of drug response.[13] Drug absorption, the amount of and the rate at which a drug enters the general circulation, depends on gastric pH, intestinal motility and surface area, passive or active transport processes, intestinal blood flow, and metabolism in the gut and portal system. The lipid soluble TADs are absorbed passively from the small intestine. With advancing age, gastric pH increases which fosters increased TAD absorption in the stomach. The significant reduction in intestinal motility, surface area, and intestinal blood flow associated with aging probably results in decreased absorption.[13,14]

The distribution of drugs in body compartments is a highly complex phenomenon in that the drug molecule first enters a central compartment which includes the blood and extracellular fluid of highly perfused tissues such as the heart, lungs, liver, kidneys, and endocrine glands, and then enters a larger peripheral compartment including muscle, skin, and body fat. The volume of distribution of the lipid-soluble TADs is greater in the aged because body fat increases from age 18 years to age 55 years from 18 to 36 percent in men and from 33 to 48 percent in women.

Although drugs in the central compartment selectively may bind to plasma proteins, red blood cells, or other body tissues, psychoactive agents including TADs bind largely to plasma proteins and red blood cells. Individual differences in drug binding, probably genetic in origin, result in varying amounts of unbound drug in the central compartment which is in equilibrium with body tissues including the brain. Thus the amount of unbound lipid-soluble TAD that crosses the blood-brain barrier and eventually affects neuronal function in the brain determines the clinical response of each individual.

The major metabolic pathways for psychoactive agents include demethylation, oxidation, and hydroxylation, followed by conjugation with glucoronic or sulfuric acid. Tertiary TADs are demethylated to secondary derivatives that also are pharmacologically active compounds as are some of the hydroxylated derivatives. The rate of metabolism can be increased by induction of liver enzymes which can occur after ingestion of many agents, including most sedative-hypnotics, caffeine, and nicotine from smoking. Aging, on the other hand, slows the rate of the metabolism of TADs and other psychoactive agents by decreasing the efficiency of liver enzyme systems.

"The elderly have less protein binding and a greater plasma free fraction and, thus, are susceptible to the benefits and the noxious effects of TADs."

The excretion of most psychoactive agents, including TADs, depends on the conversion of these lipid-soluble substances to water-soluble ones and their elimination by the kidneys or other organs. The decreased renal blood flow, glomerular filtration rate, and urea clearance that occur in the aged have been postulated to result in increased accumulation of some psychotherapeutic agents. After being demethylated to secondary amines, TADs are metabolized to compounds such as the hydroxylated derivatives, some of which possess antidepressant activity. Therefore, accumulation of active metabolites because of decreased renal function may be of significance with TADs as in other classes of psychoactive drugs.[15]

Aging, then, has a complex effect in response to TADs. It results in physiologic changes that can alter pharmacokinetics either positively or negatively, depending on the site studied. Factors that would result in lower TAD levels include decreases in intestinal surface area and intestinal blood flow. On the other hand, factors that would result in higher TAD levels include increased body fat, decreased binding to plasma proteins, and decreased liver metabolism.

PHARMACODYNAMIC FACTORS

Pharmacodynamic factors, the effects of the drug at the receptor site, are thought to be important in drug response, and there is some research to indicate that there are changes

) receptor sensitivity from youth to age and under varying eatment conditions.[16,17] Of particular interest in this regard re recent neurotransmitter receptor binding studies that ave led to the development of radio receptor assays for rugs. In such an assay, one measures the binding of the adioactive drug to the receptor and monitors drug content f the patient's plasma by its ability to decrease receptor inding. Radio receptor assays now have been used to easure TADs and may in time become clinically available. uch assays would provide a more specific assessment of the erapeutic effect of the drug as measured in receptor ccupancy units, while the present TAD plasma levels easure the unbound TAD plasma levels but do not provide nformation on the effect of the drug at its receptor site on ie central nervous system neuron.[18]

Interpretation of TAD plasma levels should take into ccount that adaptive processes to prolonged drug exposure ccur within the central nervous system. Thus, chronic eprivation of the neurotransmitters, norepinephrine and opamine, could lead to increased numbers of receptors on ie postsynaptic cell, resulting in supersensitivity; prolonged AD administration, if it resulted in greater levels of the eurotransmitters at the neural junction, ultimately could sult in a reduced number of receptors and to tolerance of ie transmitter (desensitization or down-regulation).

"The amount of unbound lipid-soluble TAD that crosses the blood-brain barrier and eventually affects neuronal function in the brain determines the clinical response of each individual."

Over a period of time the mechanisms underlying the erapeutic effect of the TAD at postsynaptic sites may be odified in ways that are not amenable to study at our resent level of knowledge. Similarly, adaptive changes volving neurotransmitter synthesis, storage, reuptake, and elease also may occur over a period of time at presynaptic tes. The influence of these factors currently is under study nd should provide the clinician in the future with greater ophistication in management of antidepressant therapy in ie geriatric patient.[17]

DVERSE REACTIONS

Adverse reactions of the aged to TADs are numerous and otentially severe; this underscores the importance of ionitoring plasma TAD levels. A large number of studies ave shown a significant association between response and lasma steady state levels of TADs. On the other hand, very igh plasma levels are associated with an increased incidence f side effects and toxicity.

No study has demonstrated that one TAD is more effec-ve than another. Side effects and toxicity of various TADs, owever, are different. Tertiary amines such as imipramine Tofranil®) and amitriptyline (Elavil®) have greater drenergic-blocking capacity, producing sedation and ypotension and greater anticholinergic effects than secon-ary amines such as desipramine (Norpramin®) and nor-riptyline (Pamelor®).

Possibly the most worrisome toxic effect of TADs is cardiotoxicity. The major cardiac effect is slowing conduction in the HIS-Purkenjie system, resulting in arrhythmias. Plasma levels are extremely important in preventing cardiotoxicity because a number of studies have shown a correlation between high plasma levels and this toxic effect.[19,20]

Elderly patients with heart disease should have EKGs and plasma TAD levels weekly and then every several months until a therapeutic level is established. In those patients with cardiac disease, consultation with a cardiologist is a prerequisite to beginning treatment with TADs. Caution should be exercised in patients with recent cardiac damage, especially those with left bundle-branch block or bifascicular block. Paradoxically, patients with certain arrhythmias, including PACs and PVCs, may benefit from TADs because these drugs exert an antiarrhythmic effect similar to that of quinidine. Dose-related EKG changes have been described; they start initially with prolongation of the P-R and Q-R-S intervals and nonspecific T wave changes, and, at higher doses, to include tachyarrhythmias, PVCs, heart block, and ventricular fibrillation.

There are several TADs in common use today which have been studied fairly extensively by plasma assay. The first studied and most thoroughly evaluated TAD is the secondary amine, nortriptyline. For this drug, a curvilinear relationship between plasma level and clinical response is reported; plasma levels of less than 50 are associated with poor clinical response and above 150 ng/ml with toxicity.

The tertiary amines, such as imipramine and amitriptyline, are metabolized to active secondary amines. In calculating the plasma level needed to achieve a therapeutic response, the combined level of the tertiary amine and its secondary metabolite must be taken into account. In contrast to nortriptyline, there is no upper limit beyond which clinical worsening occurs. Thus, it usually is stated that imipramine and amitriptyline have a linear-dose response curve rather than the curvilinear-dose response relationship described for nortriptyline. For the tertiary amine, amitriptyline, and its secondary amine, nortriptyline, combined plasma level of 150 ng/ml or more has resulted in maximum therapeutic response. Imipramine and its secondary amine, desipramine, require a minimum combined plasma level of 150 to 240 ng/ml.

Therapeutic plasma levels of other TADs are available from the laboratories performing these studies. However, the relationship of plasma levels to clinical response has not been studied adequately in the other antidepressants to date and controversy over the value of routine monitoring of tricyclic plasma levels remains lively in the literature.[21,22] There is more clinical agreement on the value of therapeutic monitoring in treatment-resistant patients and those such as the aged who are at special risk of cardiotoxicity and other troublesome side effects of the TADs.

The following case history shows the role of TAD level determinations in the successful management of depression in the elderly person.

CASE HISTORY

A 76-year-old, white, married male was admitted to Carrier Foundation with a depressive syndrome of five months' duration. He had no interest in his part-time work and had loss of appetite, weight and energy, and poor sleep. He did not experience hallucinations or delusions. His diagnosis was major depression, single episode.

On admission, the patient was started on imipramine

hydrochloride, which was increased over a 10-day period to a maximum of 200 mg daily. At this level, he had dizziness, lightheadedness, and drowsiness which precluded further increases although his depressive symptoms persisted. A TAD level performed 11 days after admission was 78 ng/ml (normal therapeutic range is >150-240 ng/ml). Since the dosage could not be raised and a therapeutic level achieved, a series of five electroconvulsive treatments was administered and resulted in remission of his depression.

This case illustrates the importance of careful diagnostic evaluation by clinical interview and the usefulness of TAD blood levels in clinical management. The patient met DSM III clinical criteria for major depression, single episode. He remained unresponsive to the TAD, even though it was administered in the traditionally recommended daily dosage of 200 mg. Serum TAD levels revealed that the patient had a subtherapeutic level of medication. Unable to increase medication because of side effects, the physician elected to use a different modality of treatment, electroconvulsive therapy, that proved effective in alleviating the patient's depression.

CONCLUSION

TAD plasma levels should be performed when the patient is felt to be on a therapeutic dosage and has achieved a steady state blood level, usually within 7 to 21 days after a regular dose of a TAD. Long-term followup with periodic TAD plasma levels, especially in patients with poor response and drug side effects, permits administration of the lowest effective dosage, ensures patient compliance, and, along with use of the EKG, enables the physician to avoid cardiotoxicity in a patient.

In patients who do not respond to the standard therapeutic dosage of TADs, biochemical assays to determine TAD levels or tests of neuroendocrine function may aid in the selection of different treatment modalities. Because of the frequency and severity of depression in the elderly and its association with increased mortality from suicide and morbidity from medical illnesses, this new strategy of clinical management of the aged depressed patient, incorporating recently developed techniques, will improve the outcome of this expanding subgroup of patients in physicians' practices.

SUMMARY

Reliable techniques for monitoring tricyclic antidepressant levels increase the likelihood of successful treatment of elderly patients with major affective disorder (MAD). Monitoring tricyclic plasma levels is becoming widespread among psychiatrists, but family practitioners and internists, who prescribe almost 70 percent of tricyclic antidepressants (TADs), are not as yet aware of the clinical usefulness of the procedure. Pharmacodynamic principles are essential to understanding TAD management in the aged. A steady state blood level of TAD is achieved when a patient has been maintained on a constant dosage for at least one week. Measurement of plasma levels at this time will allow the physician to determine whether a therapeutic level of medication has been achieved. With this information, the physician is able to administer the lowest effective dose, ensure patient compliance, and avoid toxicity. A case illustrating the role of TAD plasma levels in patient management is presented.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The followng is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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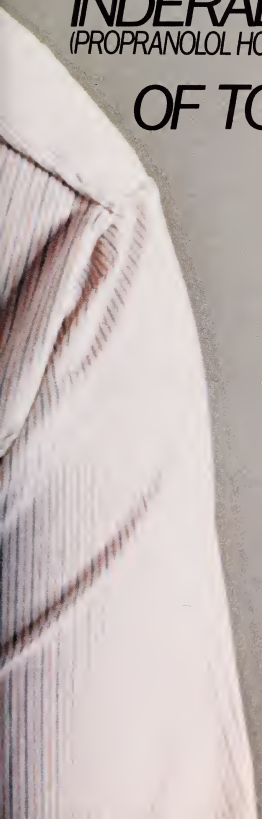
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WARNINGS

CARDIAC FAILURE. In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn. b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levarterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY. Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands, arterial insufficiency usually of the Raynaud type, thrombocytopenic purpura. *Central Nervous System* lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory* bronchospasm. *Hematologic* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous* reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings.* Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

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The Pathophysiology of Head Trauma

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The pathophysiology of head trauma is reviewed. The differing concepts between a mass lesion and a diffuse injury to cellular structures of the brain are reviewed. Our changing understanding of the management of increased intracranial pressure is discussed.

The normal function of the central nervous system (CNS) is protected mechanically by the skull, physiologically by the blood-brain barrier, and chemically by the autoregulation of the blood flow. These mechanisms protect the function of the neurons and glia which are very sensitive to compression, deprivation of blood supply, and exposure to toxic substances.

The skull serves to protect the brain. This thick layer of bone is perforated by several foramina and is divided into two large compartments communicating through the tentorial incisura. Because the bone of the calvarium essentially is nondistensible, the volume of the intracranial space is constant, irrespective of the pressure generated within it. The intracranial space is filled to capacity with fluid in and around the brain and blood vessels and solid materials so that its contents are nearly incompressible. These facts represent the basis of the Monro-Kellie doctrine.** However, there are certain compensatory mechanisms that allow for some increase in volume without change in pressure. This is the basis of the pressure-volume curve that varies in individual patients; it can be predicted with only limited accuracy.

Blood is delivered to the brain through a system of conducting and penetrating vessels.[1] The concept of a blood-brain barrier and cerebrospinal fluid barrier has been derived from observations that various compounds that rapidly enter and distribute within most organs and tissues are excluded from the brain and cerebrospinal fluid. This is possible because cerebral capillaries differ anatomically from those of the remainder of the body in that they have tight junctions between the endothelial cells and are surrounded by astroglial foot processes. The tight junctions can be said to comprise the anatomical and, probably, the functional blood-brain barrier because the junctions make it extremely difficult for nonlipid-soluble and some other substances to enter the brain interstitial space.

Autoregulation refers to the ability of the vascular bed of the brain to maintain constant flow in the face of changing perfusion pressure. The penetrating or resistance vessels of the brain are sensitive to metabolic changes, but are less influenced by the autonomic nervous system than similar blood vessels in other organs.

Under normal conditions, blood flows through the brain at a rate of approximately 750 ml/min or 50 ml/100 gm of brain. The cerebral blood flow (CBF) nearly is constant despite wide variations in cerebral perfusion pressure which

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**The Monro-Kellie doctrine states that the quantity of blood within the cranium must be approximately constant at all times; the doctrine refers to the quantity of blood, not blood flow.

is determined by the difference between the arterial and intracranial (venous) pressures. The normal range of autoregulation appears to be between 45 and 150 mm/Hg cerebral perfusion pressure. Within the range, CBF is unaffected by systemic pressure because of independent adjustments in the diameters and resistances of the cerebral arterioles. Pressures above the normal limit produce capillary hypertension and dilatation, whereas pressures lower than 40 mm/Hg induce cerebral ischemia.

CBF is autoregulated in response to increased intracranial pressure (ICP) in much the same way it is during periods of decreased systemic arterial pressure. Therefore, when autoregulation is intact and ICP is elevated, CBF does not fall until the cerebral perfusion pressure is reduced to less than 40 mm/Hg. Autoregulation is lost when the pH around the cerebral arterioles falls because of cerebral acidosis such as may occur in head trauma. Marked acidosis maximally dilates the arterioles and abolishes or reduces their responsiveness to systemic blood pressure. In fact, when autoregulation is defective, CBF varies linearly with perfusion pressure.

Alteration of the pCO_2 will have a major effect on CBF. For example, increasing pCO_2 from 20 to 40 will double the cerebral blood flow by dilating the arterioles and increasing both blood volume and blood flow. In head-injured patients, however, the increased pCO_2 of the blood actually may reduce the cerebral circulation in the damaged areas. This may occur when the vessels in the injured areas are dilated maximally owing to tissue acidosis and only the vessels in healthy areas can dilate in response to raised arterial pCO_2. The result is blood shunted through or from the impaired areas, a phenomenon called the luxury perfusion syndrome or intracerebral steal syndrome.

The pathophysiological mechanisms operative in patients suffering from head trauma are numerous; in many instances, their interrelationships are understood poorly. In all types of injuries, however, there is trauma to the cells and microvasculature. The degree of injury is determined by the compound effects of the mechanical damage to the cells, disruption of the blood-brain barrier, extravasation of blood, and loss of autoregulation. In addition, blood extravasated within the skull, either within the brain or outside of it, can assume the role of a mass and can cause secondary, often fatal, injury to essential neural structures. Therefore, there are two categories of injuries.

Mass Lesions. In patients with intracerebral, subdural, or epidural hematomas, the injury to the brain itself may not be extensive but the extravasation of blood can lead to the elevation of intracranial pressure and the development of a vector of forces. This vector of forces causes movement of the brain within and through the compartments of the skull and eventually pushes the brain into the naturally present openings between them. The mass of compressed brain then secondarily compresses other vital parts of the central nervous system causing a herniation. The two most common types of herniation are transtentorial and tonsillar. In the first type, the brain stem is pressed against the edge of the tentorium; in the second type, the medulla is compressed. In both cases, the cellular structures of the brain stem and medulla are compromised and later its vasculature is damaged. These lesions become independent of the original ones. If the hematoma mass is evacuated surgically before such events take place, secondary injury within the brain stem and the medulla may be prevented. If there is a delay in removal of the blood clot, injury to the brain stem or medulla may become irreversible.

Diffuse Parenchymal Lesions. In a closed-head injury there is more extensive damage. No mass can be evacuated surgically because injury usually is diffuse. Depending on the severity of the injury, the morphological substrates range from transient membrane depolarization to total anatomical disruption of the neurons, glia, and microvasculature. There may be extravasaton of a small amount of blood into the brain parenchyma and subarachnoid space. Both of these processes are accompanied by potassium ion ($K+$) release from the injured cells into the extracellular space and concomitant calcium ion ($Ca+$) depletion.[2,3] The $K+$ release, which appears to be transient in most instances, blocks neuronal transmissions, causes significant increase in vascular resistance, and induces the uptake of water into the glial and probably into neuronal cells. The decrease in $Ca+$ affects cell permeability, decreases metabolic activity, and blocks synaptic transmissions.[3] This leads to cellular dysfunction and swelling even outside the damaged area. In addition, the disruption of the blood-brain barrier leads to extravasation of proteinaceous substances and extracellular edema.

Changes in the cerebral vessels always are present to some degree in severe trauma. They include a microvascular constriction, compression, and spasm in major vessels. It appears that the earliest phase in head trauma is accompanied by actual increase in the intracerebral intravascular volume which is thought to be due to the paralysis of the venous system and passive congestion; the late phase is associated with the development of ischemic infarcts. It is not clear whether the ischemic infarcts are caused by a decreased flow through the constricted "spastic" vessels or whether they are the result of massively increased peripheral vascular resistance induced by the changes in the ionic milieu or mechanical compression.

The clinical picture is determined by the local extent and severity of the lesion as well as by its location within the neural axis. Thus, two lesions, comparable to each other in extent and severity, may produce a totally different picture if, for example, one is located in the frontal lobe and the other located within the brain stem. The first may not cause any appreciable neurological deficit while the other may result in deep coma.

Most types of head trauma are accompanied by elevation of intracranial pressure (ICP). There are several stages of the ICP elevation that have different pathophysiological causes and significance. The first increase in ICP takes place during the stage of $K+$ release and the vasoparalysis. The second is caused by the development of cellular swelling induced by the initial trauma and the profound biochemical changes affecting the cellular membranes and ionic equilibrium. Extravasation of proteins and particles of blood across the damaged blood-brain barrier (BBB) adds to the problem. This is the stage where various treatment modalities including hyperventilation and administration of mannitol and steroids are most effective.

The tertiary and terminal increase in intracranial pressure is caused by the combination of micro- and macroinfarcts, disruption of all cellular function, and the blood-brain barrier. This increase may take place within minutes after injury and be present when the patient arrives in the emergency room. Since there is no effective treatment for the damage caused by deprivation of the neural cell of its

metabolic substrates there is no effective way of controlling the tertiary increase in ICP. This increase, however, is not the cause but is the reflection of the cellular dysfunction. Therefore, attempts should be made to prevent this event from developing rather than trying to treat it.

The role of ICP in head trauma has been reconsidered and new questions constantly are raised. Although the classical concept is that elevated ICP is the cause of neuronal dysfunction, evidence is accumulating that in many instances the elevation in ICP is a reflection of cellular dysfunction rather than its cause. Although therapy that leads to a decrease in intracranial pressure appears to be beneficial, the clinical outcome after severe trauma or spontaneous subarachnoid hemorrhage may fail to improve. This indicates that ICP is not the only and may not even be the primary determinant of the clinical outcome in some patients.

PATHOPHYSIOLOGICAL CONCEPTS IN THE TREATMENT OF HEAD TRAUMA

The treatment of a large mass lesion is surgical removal as rapidly as possible before herniation occurs. The treatment of a closed-head injury utilizes several modalities that also are used in patients in whom a mass has been surgically removed. Controlled respiration, steroids, and the control of ICP are the principal techniques although other treatments have been introduced recently. Controlled respiration assures an adequate 0_2 delivery to cells that are much more susceptible to anoxia after injury. Regulating the pCO_2 adjusts the size of the vessels and intracranial volume in the uninjured brain and, thus, affects the intracranial pressure. This is one of the most effective treatment modalities and remains the mainstay of therapy. Intravenous administration of large doses of steroids is used almost routinely although its effectiveness in clinical trials has not been demonstrated convincingly. It is aimed at improving the function of the injured cells by stabilizing their membranes. While steroids cannot be expected to restore the integrity of anatomically destroyed cellular membranes, they may improve the function of cells at the periphery of the lesion that were functionally disrupted but remained anatomically intact. This may decrease edema and the extent of secondary injuries and preserve marginally injured cellular structures. Recent reports of significant improvements in the quality of survival in patients with closed-head trauma receiving high doses of steroids, would support this hypothesis. Megadoses of steroids, however, have not been accepted by everyone as a routine treatment at present

The administration of mannitol intravenously leads to a significant acute decrease in ICP which is useful as a temporary measure prior to a surgical removal of a mass lesion. Its effectiveness in more chronic treatment of closed-head trauma is debated although it often is used empirically. However, ICP must be monitored while it is being used. Its mode of action has not been defined. Osmotic decrease in cellular and extracellular water in the uninjured brain, the prevention of secondary ischemic changes in the injured parts by decreasing intracranial pressure, changing the ionic milieu in the extracellular space, improving the perfusion, and decreasing the blood viscosity all have been suggested.

The use of furosemide and other diuretics that affect the $Na+/K+$ pump action is based on their direct diuretic effect and on the laboratory-documented effect of decreasing the amount of cellular swelling induced by the elevated extracellular level of $K+$. Furosemide is used routinely in some centers, but its role in the treatment of closed-head injury is not well defined.

The use of high dose barbiturates or "barbiturate coma" has been advocated on the basis of their ability to decrease intracranial pressure and cerebral metabolic demand. Since barbiturates also have many other effects, their action may be through several other mechanisms as well. Despite great potential, their effectiveness in severe head trauma has not been demonstrated convincingly and they probably should not be used routinely at present without precise laboratory and EEG monitoring.

No treatment can restore the function of anatomically destroyed cells. The aim of treatment should be prevention of secondary injuries. The functionally disrupted but anatomically intact cells in the vicinity of the mechanically destroyed cells should be the primary targets of treatment. Conceptually, two different approaches are possible. One is to attempt to suppress the metabolic demand and await the natural reparative processes to take place spontaneously. This approach currently is represented most closely by the use of barbiturates. The second approach is to stimulate the remaining metabolic functions early in order to prevent the development of cellular swelling, microvascular compression and other secondary changes in cells that have been injured marginally at the time of the initial trauma. These two concepts are not mutually exclusive. Providing that the exact sequence of events in head trauma is established, drugs resulting in suppression and stimulation of metabolic processes can be used in temporal sequence. Currently, we are in the process of testing these concepts on several therapeutic substances in our laboratories.

SUMMARY

The normal function of the brain is assured by a complex of mechanical, chemical, and physical protective mechanisms. Head trauma causes disruption in the function of the blood-brain barrier, cerebral blood flow, and cellular metabolism and is accompanied in most cases by elevations of intracranial pressure. Two main types of lesions can be recognized: mass lesions and diffuse parenchymal lesions. The elevations in intracranial pressure (ICP) that accompany mass lesions need to be treated rapidly by the surgical removal of the offending mass. In the presence of diffuse parenchymal lesions, on the other hand, the elevations of ICP may be a reflection rather than the cause of the brain dysfunction, and lowering of ICP in itself may have only limited value. Control of pCO_2 and pO_2, as well as blood pressure immediately after head trauma, is essential to combat cerebral swelling and to prevent or minimize secondary ischemic damage.

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Digital Subtraction Angiography

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Digital subtraction angiography (DSA), also called digital vascular imaging and computerized fluoroscopy, is a relatively new technique that allows visualization of arterial anatomy after an intravenous injection of radiographic contrast material. It is safe, accurate, and easily performed in an outpatient setting. The procedure particularly is useful for the detection of extracranial cerebrovascular disease, renal artery stenosis, and localized peripheral vascular disease.

With the development of new imaging techniques, vascular disease can be diagnosed and evaluated with substantially reduced patient risk and discomfort as compared to direct arterial invasion. Digital subtraction angiography (DSA), also known as digital vascular imaging and computerized fluoroscopy, permits visualization of arteries after the intravenous injection of iodinated contrast.[1,2] We describe our experience with DSA in 250 patients in an outpatient facility.

MATERIALS AND METHODS

The digital system** entails computer processing of video signals obtained from a fluoroscopic image intensifier***.[3] Initially, a fluoroscopic image is converted from analog to digital form; it is stored digitally as a number of picture elements. This initial mask image is subtracted electronically from successive frames containing intravascular contrast, and the resultant images of arteries immediately are available for review.[4] The image-mask pair can be altered to select the frames with the most diagnostic information, and both brightness and visual contrast can be adjusted.

Via an antecubital vein, preferably the right basilic, a 6.7 French pigtail catheter is positioned in the superior vena cava. In those patients with unsuitable arm veins, the femoral vein is used as access to the inferior vena cava. For carotid studies, the patient is immobilized and instructed not to swallow; for abdominal studies, intravenous glucagon and abdominal compression are utilized. Injection of contrast is performed using a power injector at a rate of 26 cc/sec for a total of 40 cc. Exposures are made at one per second and the subtracted images are viewed immediately. Additional sequences are performed as necessary to visualize the desired arterial structures. After the necessary diagnostic information has been obtained, the catheter is removed and, after a period of observation, the patient may leave the office. Adequate hydration is stressed before and after the procedure.

Of our first 250 patients, 208 patients were studied for possible extracranial cerebrovascular disease, 14 patients were studied for possible renovascular hypertension, 16 patients were studied for peripheral vascular disease, 5 patients were studied for intracerebral pathology, 6 patients were studied for mediastinal or hilar mass, and 1 patient was studied for possible celiac artery stenosis. The arm route was utilized for venous access in most patients.

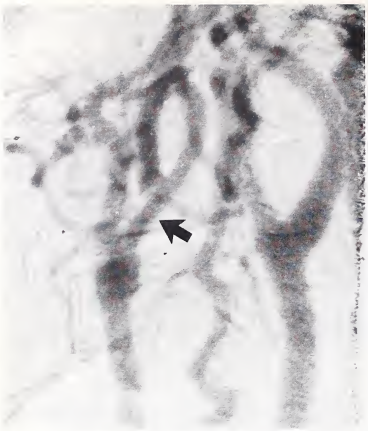
RESULTS

By far the most common examination in our series has been the evaluation of the extracranial carotid and vertebral

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A



B

Figure 1—Normal carotid bifurcation in **(A)** right posterior oblique and **(B)** left posterior oblique projections. Arrow indicates right internal carotid artery. The use of multiple projections eliminates overlapping vessels and allows for optimal visualization of both bifurcations.

vessels. Indications included transient ischemic attacks, carotid bruits, syncope, and vertebrobasilar insufficiency. Visualization of both common carotid bifurcations was considered excellent or good in 194 of 208 patients (93 percent). Of these, 78 patients were considered normal (Figure 1). Among the abnormal studies, 45 patients showed stenosis greater than 50 percent of the distal common or

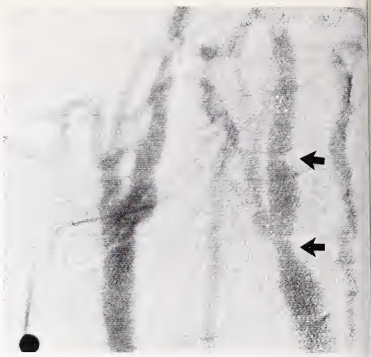


Figure 2A—DSA showing stenosis in the distal left common carotid artery and proximal left internal carotid artery (arrows).

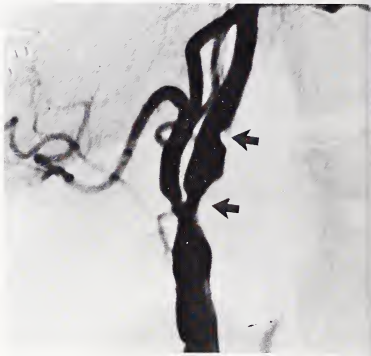


Figure 2B—Subtraction arteriogram confirming the findings noted on the intravenous study (arrows).

proximal internal carotid artery (Figure 2), 22 patients showed definite ulcerated plaque (Figure 3), 22 patients had total occlusion of an internal carotid artery (Figure 4), and one patient had total occlusion of a common carotid artery. Thirty-six patients had mild carotid abnormalities (stenosis less than 50 percent, no ulcerated plaque). In 13 patients, one or both carotid bifurcations were not well seen, usually because of patient motion (swallowing) or overlapping vessels that could not be resolved despite various projections. Gross vertebral findings were noted, including stenosis, occlusion, and hypoplasia. Correlation with arteriography, although limited in our series, has been excellent in patients with optimal visualization of the carotid bifurcations on the digital study (Figure 2).

Four patients were studied expressly for suspected intracranial abnormalities. In one patient, referred for evaluation before transphenoidal removal of a pituitary adenoma, extrasellar mass effect was seen, but no aneurysm

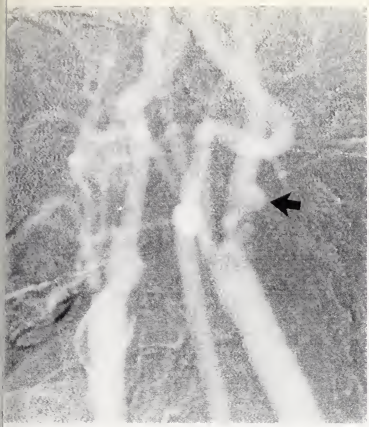


Figure 3—Significant stenosis with definite ulcerated plaque (arrow) in the proximal left internal cartoid artery.

was noted. A second patient was studied as a followup to surgical excision of an arteriovenous malformation and showed no residual or recurrence.

Of 14 hypertensive patients studied for possible renovascular hypertension, 3 patients demonstrated unilateral stenosis, 1 patient demonstrated bilateral stenosis, 1 patient showed changes of fibromuscular hyperplasia, 1 patient demonstrated a hypoplastic renal artery, 1 patient demonstrated an occluded renal artery, and four patients were normal (Figure 5). Three cases were reported as "probable" stenosis, requiring further study.

Sixteen patients were studied for peripheral vascular disease and diagnostic results were achieved in all. Among the abnormalities noted were iliac, femoral (Figure 7), and popliteal stenosis, graft occlusions, and subclavian occlusion with "subclavian steal."

Patients were studied for thoracic aortic aneurysm, right aortic arch, and mediastinal or hilar mass. DSA particularly was useful to determine if a hilar or perihilar density represents a pulmonary arterial or venous structure, rather than a tumor mass or lymph node.

We are not aware of any major complications. Four patients with atherosclerotic cardiovascular disease had angina following the injection of contrast which was relieved promptly by nitroglycerine. Minor ecchymosis followed venous catheterization in rare cases. Adequate hydration is stressed pre- and postprocedure to diminish potential renal toxicity.

DISCUSSION

In 1951, Fisher observed that cerebral infarction could result from stenosis of the common carotid bifurcation,[5] and since then it has been estimated that 35 to 40 percent of all strokes are caused by atherosclerosis in the extracranial carotid arteries.[6] Although some controversy remains regarding the relative roles of atherosclerotic emboli from ulcerated plaque and hemodynamic stenosis at the bifurcation in the pathogenesis of stroke, it is clear that extracranial carotid

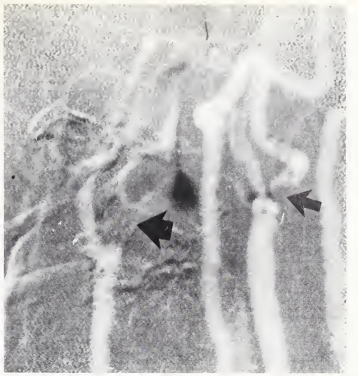


Figure 4A—Total occlusion of the right internal carotid artery at its origin (large arrow). On the left, there is a critical stenosis at the origin of the internal carotid (small arrow) as well as tiny ulcerations.

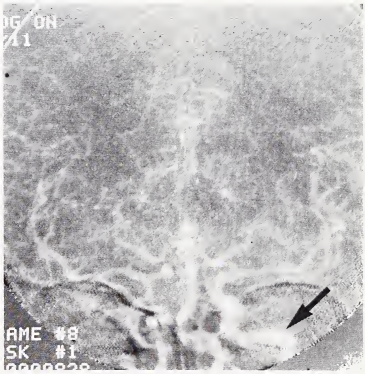


Figure 4B—View of intracranial vessels shows good filling of left internal cartoid artery (arrow), but absent filling of the occluded right internal carotid.

disease constitutes a preventable cause of stroke.[7] Arteriography has been considered the "gold standard" in the detection of carotid disease, but because of its risks, difficulty, and expense, it is not practical as a screening examination.[8] While having claims for accuracy, noninvasive vascular examinations including oculodynamometry, oculoplethysmography, phonoangiography, Doppler imaging, and real-time ultrasonography are indirect methods, highly operator dependent, and often cannot distinguish ulcerated plaque and mild stenosis from normal vessels. These methods often cannot distinguish a potentially surgically correctable high-grade stenosis from complete internal carotid occlusion.[9] In addition, these methods cannot visualize the vertebral arteries or the aortic arch vessels.

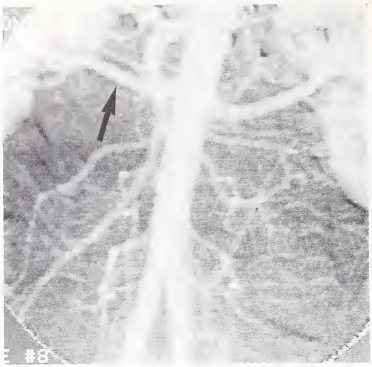


Figure 5—Frontal **(A)** and right posterior oblique **(B)** views of normal renal arteries. Arrows indicate right renal artery.

Digital subtraction angiography visualizes arterial structures directly, without the cost, risk, or expense of standard arteriography.[18] In patients in whom arteriography may have a high risk-benefit ratio, DSA can serve as an effective screening procedure. If the carotid arteries are well seen and appear normal on the digital study, no further procedure need be done. If, on the other hand, clear-cut pathology is visualized at DSA, appropriate surgical or medical therapy can be instituted directly, again eliminating the need for arteriography. In cases of less than optimal visualization of the carotid bifurcations on the intravenous study, angiography often is indicated if the clinical picture or noninvasive studies are compelling. Chilcote el al. from the Cleveland Clinic describe excellent correlation between digital substraction angiography and conventional arteriography in 97 percent of patients when the bifurcations are well seen at DSA.[10]

DSA can be useful to evaluate the intracranial circulation in selected cases. For example, because the large vessels

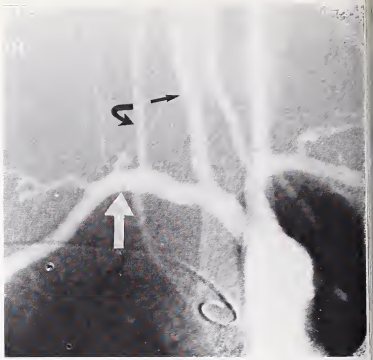


Figure 6—Normal right subclavian artery in left posterior oblique projection (arrow). Note right common carotid (small arrow) and right vertebral artery (curved arrow).

consistently are well seen, DSA is adequate to visualize the juxtasellar carotid arteries prior to transphenoidal surgery or the dural sinuses prior to removal of a meningioma.[11] DSA may be a suitable alternative to angiography after surgery for arteriovenous malformations or intracranial-extracranial bypass procedures. Because of its limited spatial resolution and the nonselectivity of injection, DSA should not replace arteriography in the evaluation of small intracranial aneurysms, arteriovenous malformations, or tumors.[11]

DSA is of value as a screening test and often as the definitive imaging study in patients with suspected renovascular hypertension. It particularly is useful when correlated with plasma renin values in predicting the outcome of successful angioplasty or surgery.[12] The Cleveland Clinic group described 59 of 70 studies considered diagnostic and 55 of these 59 accurate when compared with arteriography.[13] Other abdominal indications include: preoperative evaluation of aortic aneurysms, evaluation of aortoiliac occlusive disease, and determining patency of major aortic branches.

Limited evaluation of peripheral vasculature is well suited to DSA. It is useful to visualize stenosis, occlusion, and aneurysms, and it is an ideal technique as a followup to transluminal angioplasty or surgery. However, because of its limited field-of-view and the resultant prohibitive contrast dose, it cannot image at one sitting the aorta to the ankles, as would be required in a preoperative arterial study. Considering the relative ease and safety of arteriography in the low aorta and leg vessels, arteriography remains the preferred method to survey the entire lower extremity vasculature.

The literature describes limited experience with DSA for the pulmonary arteries and cardiac chambers.[14] Other potential uses include evaluaton of left ventricular ejection fraction and regional wall motion abnormalities, as well as quantitative measurements of blood flow through normal and diseased arteries.[15]

There is considerable disagreement regarding the best route of contrast administration.[14,16,17] A curved central catheter with multiple sideholes allows delivery of a larger, more concentrated bolus than a smaller peripheral catheter, improving vascular detail. Also, the central route largely eliminates the possibility of venous rupture and extravasa-

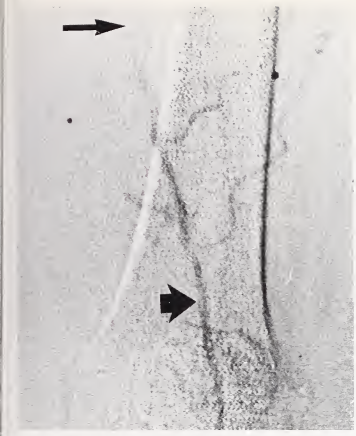


Figure 7A—Occlusion of superficial femoral artery (arrow) with reconstitution of popliteal artery (arrowhead). Note multiple collateral vessels.

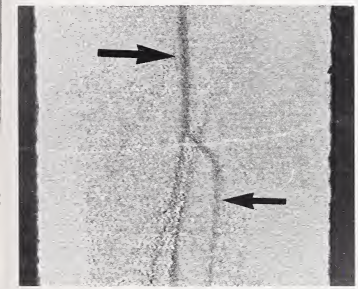


Figure 7B—A view of the upper calf vessels documents three-vessel runoff. Upper arrow = popliteal artery. Lower arrow = anterior tibial artery.

tion of contrast material that can be a problem with the peripheral route.[16]

The spatial resolution and, hence, the accuracy of DSA can be seriously limited by patient motion, including swallowing and coughing in carotid studies, and respiration and peristalsis in abdominal studies. Patient cooperation is mandatory. Selection of various frame-mask pairs usually results in suitable diagnostic images, often despite patient motion. Glucagon and compression are of value in the abdomen, and recent computer software allows correction of "misregistration" between mask and frame. The potential renal toxicity of iodinated contrast sets a limit to the number of injections that can be performed safely in one examination, particularly in diabetics. In the future, new contrast agents with little or no potential for renal toxicity may remedy this problem. Nonionic contrast agents may reduce swallowing and other involuntary motion as well.

Despite these limitations, the many advantages of DSA, including a high degree of accuracy, low risk, relatively modest cost, outpatient performance, and good patient acceptance will assure a significant role for DSA in the evaluation of vascular disease.

SUMMARY

Our experience with 250 patients evaluated by digital subtraction angiography in an office setting is presented. By far, the majority of patients were studied for extracranial occlusive vascular disease. Excellent or good visualization of both carotid bifurcations was achieved in 93 percent of patients. Patients with suspected renovascular hypertension, intracranial pathology, and peripheral vascular disease were studied as well. **Note added in proof:** Since the time of compiling data for this paper, we have performed a total of over 1,300 examinations with similar results.

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CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma; 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time, can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn. b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg. propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY beta-blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levarterenol. However such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Because of its beta-adrenergic blocking activity propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY: The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura. *Central Nervous System:* lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal:* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic:* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory:* bronchospasm. *Hematologic:* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous:* reversible alopecia. Ocular mucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings:* Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS:
—Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains **10 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).
—Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains **20 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).
—Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains **40 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).
—Each hexagonal-shaped, pink, scored tablet is embossed with an "I" and imprinted with "INDERAL 60," contains **60 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0426-81) and 1,000 (NDC 0046-0426-91), and in unit dose packages of 100 (NDC 0046-0426-99).
—Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains **80 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).
The appearance of these tablets is a trademark of Ayerst Laboratories.
Store at room temperature (approximately 25° C).

INJECTABLE
Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).
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Netilmicin in the Treatment of Gram-Negative Bacillary Infections

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Twenty-three patients with urinary tract infection, chronic osteomyelitis, or soft tissue infection were treated with netilmicin. Eighteen patients (78 percent) had a good clinical and bacteriologic response. The primary side effects were transient changes in blood chemistry values. Netilmicin appears to be a safe and effective treatment for infections due to susceptible organisms.

Netilmicin, a new semisynthetic, aminoglycoside antibiotic obtained from *Micromonospora inyoensis,* is the ethyl derivative of a dehydrogenated gentamicin C_{1a}.[13] *In vitro,* netilmicin's activity against gentamicin-susceptible clinical isolates is similar to that of gentamicin and other aminoglycosides (i.e. sisomicin, tobramycin, amikacin).[8] Furthermore, it is more active against a number of *Escherichia coli* and *Klebsiella* that contain plasmid-mediated acetylating and adenylating enzymes.[7] Animal studies show less nephrotoxicity with netilmicin than with other aminoglycosides. There is less ototoxicity seen in cats [10] and squirrel monkeys.[5] Based on the results of these studies, we decided to evaluate the efficacy and safety of netilmicin in the treatment of gram-negative infections in people.

MATERIALS AND METHOD

All patients enrolled in the study were hospitalized at Saint Michael's Medical Center, Newark. The diagnosis of gram-negative infection, for which an aminoglycoside antibiotic would be appropriate, was confirmed or strongly suspected. All patients or their immediate families were informed of the nature of the study and the potential side effects of the drug. An informed consent was signed prior to initiation of therapy in accordance with the guidelines of the hospital research committee.

Netilmicin was administered alone by intramuscular injection, at a dose of 6 mg/kg/day in three divided doses; the sulfate form of the drug was used.**

Nomograms for gentamicin, based on serum creatinine values and blood levels, were used based on the data of Jahre et al. which suggest that the pharmacokinetics of netilmicin and gentamicin are similar.[6]

Bacteriologic smears, blood, and infected body fluids for cultures were obtained from each patient—before, during, and after the course of therapy. Bacterial pathogens were isolated and identified by standard methods. Susceptibility testing for all isolates was determined by the standard antibiotic disc technique (Kirby-Bauer method).

Blood samples for serum assay of netilmicin levels were collected on the first day of treatment following the first dose, every fourth day during treatment after any dose, and on the final day of treatment after the last dose. The blood was drawn, when possible, one hour and eight hours after administration of the drug (peak and trough levels). All serum assays were done by the Schering-Plough laboratories using a modified agar-diffusion method.[1]

The efficacy of the drug was evaluated on the basis of clinical improvement and bacteriologic response by one of the investigators. Signs and symptoms of infection were

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**Schering-Plough Research Division supplied the drug in 2 ml ampules, each milliliter contained 100 mg of netilmicin base.

TABLE 1

Patients Treated With Netilmicin

Age	Sex	Pathogen	Infection	Disease	Treatment*	Outcome: Clinical	Outcome: Bacteriological
40	F	*E. coli*	UTI**		9	Cure	Cure
52	F	*E. coli*	UTI**	Chronic renal failure	12	Failure	Cure
81	F	*E. coli*	UTI	ASHD	9	Cure	Cure
58	F	*E. coli*	UTI	ASHD	10	Cure	Cure
72	F	*E. coli*	UTI	ASHD; diabetes.	9	Cure	Cure
93	F	*E. coli*	UTI	Organic brain syndrome	10	Cure	Cure
		P. aeruginosa					Cure
66	F	*P. aeruginosa*	E. gangrenosum	Felty syndrome	3	Failure	Failure
54	F	*E. coli*	UTI	Cirrhosis	10	Cure	Cure
70	F	*E. coli*	UTI		11	Cure	Cure
		P. mirabilis					Cure
		K. pneumoniae					Cure
63	M	*P. rettgeri*	UTI	Chronic vertigo	10	Cure	Cure
		P. mirabilis					Cure
83	F	*E. coli*	UTI	Neoplasm	10	Cure	Cure
60	M	*Citrobacter*	Osteomyelitis		10	Cure	Cure
62	F	*P. mirabilis*	UTI	Collagen vascular	9	Cure	Cure
34	M	*P. mirabilis*	UTI	Coma; indwelling catheter	10	Cure	Cure
40	F	*P. mirabilis*	Osteomyelitis		20	Improve	Failure
		P. morgani					Failure
20	F	*P. mirabilis*	Subcutaneous	Neoplasm	17	Cure	Cure
46	M	*Citrobacter*	Osteomyelitis		18	Improve	Failure
		P. mirabilis					Failure
69	M	*K. ozaenae*	UTI	Neoplasm	10	Cure	Cure
17	F	*E. coli*	UTI		8	Cure	Cure
52	F	*E. coli*	UTI	Hypothyroidism; diabetes.	9	Cure	Cure
25	M	*P. aeruginosa*	Osteomyelitis		27	Cure	Cure
62	F	*E. coli*	UTI	Diabetes	9	Cure	Cure
57	M	*P. mirabilis*	Osteomyelitis	Chronic lung disease;	9	Improve	Failure
		P. aeruginosa		ASHD			Failure
		E. cloacae					

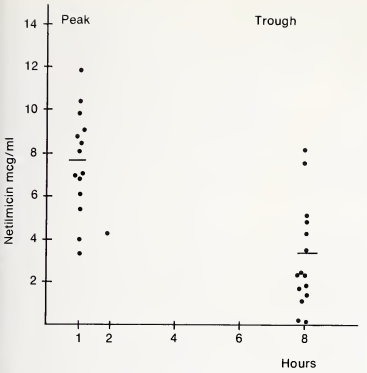
UTI: Urinary tract infection.
ASHD: Atherosclerotic heart disease.
*=days.
**=bacteremia.

TABLE 2

Comparative In Vitro Activity of Netilmicin, Gentamicin, and Amikacin Against Bacteria Isolated

Organism	Netilmicin R*	Netilmicin I**	Netilmicin S***	Gentamicin R*	Gentamicin I**	Gentamicin S***	Amikacin R*	Amikacin I**	Amikacin S***
Escherichia coli			12			12			12
Proteus mirabilis			8	1		2			6
Pseudomonas aeruginosa	1	1	2	1		3			4
Citrobacter			1			1			1
Klebsiella pneumoniae			1			1			1
Klebsiella ozaenae			1			1			1

R* =Resistant (zone diameter 11 mm or less)
I** =Intermediate (zone diameter 12 mm to 13 mm)
S***=Sensitive (zone diameter 14 mm and above)



Figure—Netilmicin serum levels.

monitored and recorded. A clinical cure was designated as a complete resolution of all symptoms and signs of the infection. Complete elimination of the infecting organism was designated a bacteriologic cure, while persistence of the original pathogen or development of a significant bacterial superinfection was considered a bacteriologic failure.

All patients were examined daily by the house staff and the investigator. Complete blood counts with differential, platelet count, chemistry profile, and urinalysis were done prior to, during, and upon termination of therapy. Every patient was questioned about side effects, particularly of ringing or fullness in the ears, headaches, and lightheadedness; all were tested for the presence of Romberg's sign, nystagmus, ataxia, and impaired hearing. Audiograms were obtained prior to and at termination of therapy when the patient's condition permitted.

RESULTS

Netilmicin was administered to 23 patients with gram-negative bacterial infections. Sixteen patients had urinary tract infection (UTI), five patients had osteomyelitis, and two patients had soft tissue infection. Two patients with UTI had positive blood cultures. Seven men and 16 women, with a mean age of 54 years (range 17 to 93 years), were treated for an average of 11 days (range was 3 to 27 days). The clinical summary is presented in Table 1.

All pathogens isolated are listed in Table 2, along with a cumulative sensitivity to netilmicin, gentamicin, and amikacin, using the standard antibiotic disc technique (Kirby-Bauer method). Six of the infections were polymicrobic. Interestingly, *P. aeruginosa* and *P. mirabilis* were found to be sensitive to netilmicin but resistant to gentamicin. Netilmicin serum levels were measured for 15 of the 23 patients several times during the treatment. The Figure illustrates the wide range of peak and trough levels achieved in these patients despite the administration of a uniform dose based on body weight and serum creatinine. The peak serum levels ranged between 3.3 and 11.9 mcg/ml with a mean value of 7.7 mcg/ml; the trough levels varied between 0.1 and 8.2 mcg/ml with a mean level of 3.4 mcg/ml. Serial peak and trough levels recorded early in the course of treatment and several days later for the same patient did not show any evidence of drug accumulation.

A complete clinical and bacteriologic cure was achieved in 18 patients (78 percent). Fifteen of the 16 patients with UTI were cured, all symptoms and signs disappeared, and urine specimens were sterile at the end of therapy and one month later. The remaining patient with UTI also had chronic renal failure. During the first five days of treatment, she received netilmicin and cephalexin—she was the only patient to receive cephalexin therapy—and by the third day her blood and urine cultures were sterile. She died 12 days after initiation of therapy from shock while undergoing hemodialysis; her death was attributed to end-stage renal disease.

Two of the five patients with osteomyelitis were cured, drainage material disappeared, and skin remained healed up to six months following termination of therapy.

The three remaining patients improved clinically, the amount of pus drained decreased, but the infecting organism was not eradicated.

One patient with soft tissue infection was cured by treatment with netilmicin therapy along with surgical drainage and debridement. One patient with ecthyma gangrenosum was withdrawn from the study because of netilmicin-resistant *P. aeruginosa*.

One patient complained of transient local pain after each injection. Four patients had transient azotemia (mean increase is 13.7 mg/dl); and three patients had transient increases in serum creatinine (mean increase is 0.3 mg/dl). Two patients had transient increases in serum alkaline phosphatase from 210 units to 230 units and from 262 units to 302 units. One patient had an increase in uric acid from 6 to 9.3 mg/dl. SGOT and bilirubin did not increase in any patient. A transient rise in the eosinophil count from 3 to 10 percent was noted in six patients. Urinalysis showed no cylindriuria, hematuria, or proteinuria. Audiometric studies were completed for five patients; all were normal prior to and at the end of therapy. One patient with tinnitus repeatedly had normal audiograms. None of the patients developed superinfection. In all, netilmicin was well tolerated and relatively free of serious side effects.

COMMENTS

When this study was conducted, reports of bacterial strains resistant to aminoglycoside antibiotics were appearing with disturbing frequency.[3,4,9] Furthermore, the toxicity of the available antibiotics also was becoming more widely recognized. We wanted to study netilmicin because it appeared to be effective against the resistant bacterial strains and yet to have minimal toxicity.

The results of our study were encouraging. The overall cure rate was 78 percent for 23 patients, including 2 patients with gentamicin-resistant pathogens. Two enzymes, an aminoglycoside acetylase (AAC-31), and an aminoglycoside phospho-transferase (APH-2) were responsible for this resistance. The comparative in vitro efficacy of netilmicin, gentamicin, and amikacin against our patients' isolates was similar to previous reports.[8]

The four netilmicin-treatment failures, one patient with ecthyma gangrenosum and three patients with osteomyelitis, most likely were due to the underlying condition rather than to antibiotic failure. Recurrent osteomyelitis rarely is controlled without the combination of careful, complete surgical debridement and prolonged (four to six weeks), high-dose parenteral antibiotic therapy.[12] This only partially was car-

ried out in these three patients.

The only death in our patient group clearly was related to uremia rather than failure of netilmicin to eradicate the infecting organism. Despite a uniform dosage regimen, there was a wide range in both the peak and trough netilmicin serum levels among our patients. This wide variation is typical of aminoglycoside antibiotics and is due to a rapid distribution phase followed by a slow elimination phase dependent on total body and renal clearance.[11] The high trough level observed in two patients was independent of renal function. This would advocate the use of netilmicin serum level as the sole guide for proper dosage.

Adverse reactions were transient. Those related to blood chemistry values were limited to chemical alterations without any permanent organ damage. Mild rises in serum alkaline phosphatase, BUN, and creatinine reverted to normal during or after cessation of therapy. One patient who developed hyperuricemia was on concomitant diuretic therapy for hypertension. We did not observe any evidence of ototoxicity in the small number of patients who underwent audiometric testings. This low incidence of nephrotoxicity and ototoxicity was confirmed in earlier reports.[2,4,5]

Netilmicin appears to be a safe and valuable antibiotic when used to treat infections due to susceptible organisms and could have future usefulness against gentamicin-resistant organisms.

SUMMARY

Twenty-three patients with urinary tract infection, chronic osteomyelitis, or soft tissue infection were treated with 6 mg/kg/day of netilmicin. Eighteen patients (78 percent) had a good clinical and bacteriologic response; 2 of the patients had gentamicin-resistant *Pseudomonas aeruginosa* and *Proteus mirabilis* infections. Three of the 5 patients with osteomyelitis improved temporarily. One patient with a urinary tract infection and bacteremia died from chronic renal failure. The mean peak and trough serum levels for these patients were 7.7 mcg/ml and 3.4 mcg/ml, respectively. The primary side effects were transient changes in blood chemistry values but no permanent organ damage occurred. One patient experienced pain at the injection site. Netilmicin appears to be a safe and effective treatment for infections due to susceptible organisms.

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CASE REPORTS

Total Electrical Alternans

SHASHI K. AGARWAL, M.D., Newark*

Electrical alternans, an uncommon electrocardiographic phenomenon, may involve different components of the electrocardiographic complex. This report reviews its characteristics. An illustrative case of total electrical alternans is presented.

Electrical alternans is an uncommon electrocardiographic phenomenon that has been defined as an alternation in the configuration of the electrocardiographic complexes arising from the same pacemaker and independent of periodic extracardiac phenomenon.[1] Although invariably connoting organic heart disease,[2] especially pericardial tamponade,[3-8] electrical alternans may be observed in the absence of organic heart disease.[9] With the advent and widespread diagnostic incorporation of cardiac ultrasonic techniques, our understanding of the underlying mechanisms of this interesting entity has been enhanced greatly.[1,10] This report illustrates a case of total electrical alternans and discusses the various features of this electrocardiographic curiosity.

CASE REPORT

The patient was a 67-year-old white male with a biopsy-proved, inoperable bronchogenic carcinoma. He was not taking medications. On the day of admission to the hospital, the patient momentarily "passed out" on assuming the upright position after a night's rest. There were no other symptoms. On examination, he appeared pale and drowsy, with labored respiration at a rate of 20/min. Pulse was 118/min and regular; blood pressure was 90/74 mm/Hg in the supine position but it fell to 70 systolic in the upright position. There was a paradoxical blood pressure response on inspiration, the systolic pressure falling by 18 mm/Hg. The jugular venous pulsations were just visible above the angle of the jaw and appeared to show a normal wave pattern. There was no peripheral edema. The patient's chest was normal shaped. The apical cardiac impulse was diffuse, and the heart sounds were muffled. No rubs, murmurs, gallops, or clicks could be heard. Lungs were clear on percussion and auscultation. Abdominal and central nervous system examinations were unremarkable. An electrocardiogram (Figure 1) revealed a sinus tachycardia, a rightward axis, and electrical alternans involving all components of the QRS complex (P-QRS-T). The latter finding was independent of the respiratory cycle. An M-mode echocardiogram (Figure 2) revealed a large anterior and posterior echo-free space (PE), representing a pericardial effusion. There is alternate anterior and posterior swinging of the heart, the posterior swing associated with increased right ventricular (RV) internal dimension, decreased left ventricular (LV) internal dimension, and a decrease in the QRS amplitude. Opposite changes are noted during the anterior swing. Cross-sectional (2-D) echocardiography similarly is demonstrated, most strikingly on the subcostal view—pendular motion of the heart as well as alternate filling of the two ventricles. On pericardiocentesis, removal of only 50 cc of a bloody effusion abolished the electrical alternation and elevated the systolic

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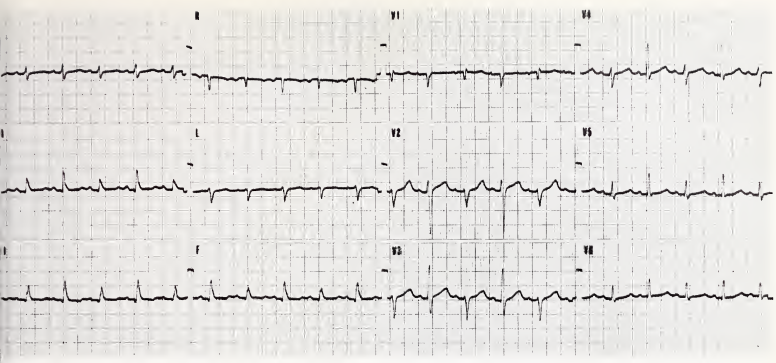


Figure 1—12-lead electrocardiogram. The rhythm is sinus tachycardia at a rate of 115/min. QRS complex alternans is apparent in all leads while P and T wave alternans is seen best in leads V1 and V2, respectively.

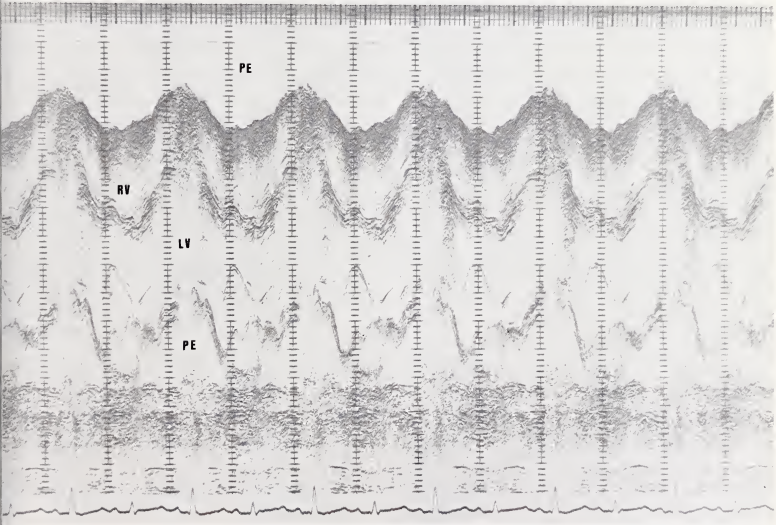


Figure 2—M-mode echocardiogram. A large pericardial effusion (PE) is noted anteriorly and posteriorly. The entire heart shows a pendular motion with the anterior swing coinciding with the large QRS complex and the posterior swing coinciding with the small QRS complex. RV= Right ventricle; LV: Left ventricle.

blood pressure to 110 mm/Hg. A total of 1,000 cc was aspirated. A repeat echocardiogram revealed normalization of the heart motion with a small effusion still persisting.

DISCUSSION

Although clinically demonstrated as early as 1910 by Lewis,[11] electrical alternans continues to be an uncommon electrocardiographic occurrence; it is observed in approximately 5 out of every 10,000 electrocardiograms taken in general hospitals.[2,12] Electrical alternans has several diagnostic characteristics:

1. There is a rhythmic change in the size and configuration of the electrocardiographic complexes. The QRS complex most commonly is involved; occasionally total electrical alternans involving both atrial and ventricular complexes (as was seen in our patient) may occur. Rarely, ST segment,[13,14] T wave,[15,16] U wave,[17] or P wave[18-20] alternans may result. Combinations of the above may be noted.[21-23]

2. The complexes originate from the same pacemaker resulting in constancy of the R-R intervals. In the rare patient with atrial fibrillation as the underlying rhythm, variable R-R intervals may be observed.

3. The changes are independent of any periodic extracardiac interference. Alternation due to respiration may be dramatic and closely may simulate electrical alternans.[24] The usual alternation ratio is 2:1, but other ratios may occur rarely.[2]

Electrical alternans may be seen with a wide variety of disorders. Ventricular alternans usually have been associated with large and hemodynamically significant pericardial effusions. Rhythmic pendular anteroposterior motion of the heart within the fluid-filled pericardial sac probably is the major etiologic mechanism.[10,25,26] Its presence in other conditions such as congestive heart failure, metabolic imbalance, or collagen disorders strongly suggests that alternating prolongation of refractoriness in parts of the heart may be the primary mechanism in some cases.[2,18,19,27] Ventricular alternans independent of the cardiac motion also has been demonstrated under experimental conditions.[28-31] Its occurrence during episodes of supraventricular tachycardia usually is considered to be of benign significance.[32]

Total electrical alternans, with involvement of all components (P-QRS-T-U) of the electrocardiographic complex, occurs almost exclusively in cardiac tamponade; the pericardial effusion usually is a result of tuberculosis or malignancy.[4,7] The echocardiogram in our patient supported the concept that pendular swinging of the heart is the usual etiologic mechanism. Simultaneous mechanical alternans may occur in these patients.[33,34] A critical amount appears necessary for the production of these findings, since removal of small amounts of the effusion may abolish the phenomenon.[31] Total electrical alternans rarely is due to other causes.[24,36]

Electrical alternans, although not in itself requiring treatment, clinically is significant since its presence always should raise the suspicion of a hemodynamically, life-threatening pericardial effusion. Further, its occurrence often is predictive of a poor course, due to its invariable association with advanced cardiac disease.

SUMMARY

Electrical alternans is an uncommon electrocardiographic phenomenon characterized by alternating change in the contour of the electrocardiographic complexes. Electrical impulses arise from the same pacemaker, and are independent of any extracardiac interference. This report describes the various types of electrical alternans and discusses their etiologic associations. A case of total electrical alternans is illustrated.

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

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Please see summary of product information on following page.

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Pasteurella Multocida Empyema with Septicemia

NIRMAL K. FERNANDO, M.D., DAVID V. ALCID, M.D.,
GARY GARTENBERG, M.D., New Brunswick*

Infections of humans due to *Pasteurella multocida* occur frequently in association with animal (usually cats and dogs) bites or exposure. We describe two patients with empyema and bacteremia due to this agent without direct wound infliction by an animal.

Animal infections caused by *Pasteurella multocida* have been recognized for almost one hundred years. The organism is known to cause fowl cholera, rabbit septicemia, swine plague, and hemorrhagic septicemia in cattle.[1] Human infections usually are secondary to animal bites; a wide range of diseases has been documented.[1,2] Patients with compromised host defenses usually develop bacteremia which often is life threatening and may or may not be associated with animal exposure or bite.

CASE REPORT 1

A 57-year-old white female with a diagnosis of congestive cardiomyopathy and mitral regurgitation was hospitalized because of uncontrolled bleeding from a varicose vein in her left leg. She had a long history of congestive heart failure and was taking digoxin, furosemide, and warfarin.

She denied smoking, alcohol consumption, or chronic sputum production. She had no pets and gave no history of animal bites, camping, or visiting a farm. On physical examination she looked chronically ill and was orthopneic: pulse 100/min.; blood pressure 128/76 mm/Hg; temperature 37°C; respirations 26/min. Head, ears, eyes, nose, and throat were unremarkable except for jugular venous distention. The heart was enlarged with a grade III/VI holosystolic murmur and a S-4 gallop. Breath sounds were absent in both lung bases. Hepatosplenomegaly and ascites were noted but there were no signs of peritonitis. The lower third of the limbs was edematous and hyperpigmented and contained numerous varicose veins. The left leg had a bleeding stasis ulcer.

Laboratory results were: hemoglobin 14.1 g/dl; WBC 6,900 cell/mm³; segs 80%; bands 4%; chest x-ray was cardiomegaly with bilateral pleural effusion.

The bleeding was controlled with pressure application and vitamin K administration.

Twenty-four hours after admission, the patient developed a shaking chill, a temperature of 40°C, and hypotension. Cephalothin, 2 gm intravenously every 4 hours, and gentamicin, 80 mgm intravenously every 8 hours, were administered after obtaining blood cultures. White blood count (WBC) was 15,200 cell/mm³. Thoracentesis (right side) aspirated straw-colored fluid with a WBC count of 10,500 cell/mm³ of which 98 percent was polymorphonuclear neutrophils; glucose 3 mg/dl (blood glucose 70 mg/dl); protein 12.6 g/dl (serum protein 5.1 g/dl); LDH 1,590 mμ/ml (normal value is 240 mμ/ ml. Gram stain of pleural fluid revealed gram-negative bacilli. Both blood and pleural fluid grew the same organism, initially identified as *Acinetobacter calcoaciticus* but subsequently identified as *Pasteurella multocida*. A thoracotomy tube was inserted into the chest on the right. Pleural fluid from the left side of the chest also grew the same organism. Culture from the left leg ulcer was negative.

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The patient was discharged 27 days after admission in a stable status, but was readmitted three months later for management of congestive heart failure. She remained afebrile throughout hospitalization and the blood cultures were sterile.

CASE REPORT 2

A 64-year-old white female with a diagnosis of cryptogenic cirrhosis was admitted to the hospital with a sudden onset of left pleuritic chest pain, dry cough, and dyspnea. She had "chilly sensations" for two weeks prior to admission, edema of her lower limbs, and a three-month-old dry ulcer of her left lower leg.

She did not smoke or drink. She had a cat but denied being bitten. There was no travel history.

The patient was in moderate distress. Physical examination revealed: pulse 104/min; blood pressure 160/100 mm/Hg; temperature 38.8°C; respirations 24/min. There were facial telangiectasia and scleral icterus. A grade II/VI systolic ejection murmur was heard at the base; it radiated to the neck. Lungs were dull to percussion in the mid and lower zones with absent breath sounds. The abdomen was negative with no palpable organomegaly or demonstrable ascites. The lower limbs were edematous to the knees with a dry ulcer on the lateral aspect of the lower left leg.

Laboratory results showed: hemoglobin 13.4 g/dl; WBC 15,000 cell/mm^3; segs 66%; bands 18%; alkaline phosphatase 21.5 units (normal 4 to 13 units); total bilirubin 2.2 mg/dl; SCOT 214 units (normal 8 to 30 units); BUN 32 mg/dl; creatinine 1.5 mg/dl; arterial blood gases: pH 7.37, PCO_2 29 mm/Hg, PO_2 67 mm/Hg, CO_2 17, 0_2 sat 91%. Chest x-ray revealed a large pleural effusion.

The patient initially was managed as if she had a pulmonary embolism. Thoracentesis of the left chest removed serosanguinous fluid with protein 3.2 g/dl; glucose 100 mg/dl (blood glucose 134 mg/dl); white blood count 19,150 cell/mm^3; segs 91%; and red blood cells 18,500 cell/mm^3. Gram stain revealed no organisms. A thoracotomy tube was placed in the left chest; both the blood and pleural fluid cultures grew *Pasteurella multocida.* She was treated with aqueous penicillin G, two million units every four hours intravenously, for two weeks. She was asymptomatic and afebrile at the time of discharge.

DISCUSSION

Swartz and Kunz described three clinical patterns of *Pasteurella multocida* infections in man. The first type was local infection with adenitis, most often after cat bites. The second type was seen in patients with chronic pulmonary infections where the organism is a primary pathogen in association with other organisms. Thirdly, they described a systemic form with bacteremia or meningitis where one may or may not obtain a history of exposure to animals. But a diversity of infections have been described ranging from brain abscess to appendiceal abscess.[1,2]

Pulmonary infections most often have been described in elderly patients with chronic underlying lung disease.[3] It has been postulated that *Pasteurella multocida* organisms may enter the body through the respiratory tract via inhalation of infectious droplets sprayed by sneezing animals.[4] Thus, occupational exposure and pets at home are important factors. In patients with chronic lung disease the organism is thought to colonize the respiratory tract and lie dormant for months.[4] If some physiologic disturbance, trauma, or infection leads to alteration of the status quo, the organis becomes a secondary invader. The second patient had r obvious lung pathology but she continuously was exposed t her pet cat and respiratory tract colonization was a poss bility. In the first patient, there was no identifiable source b she probably had a chronic pleural effusion secondary t congestive heart failure. One may speculate that the o ganism entered the blood stream from the bleeding ulcer an then infected the pleural space.

Reported studies of healthy animals have demonstrate isolates in 12 to 54 percent of dogs and 52 to 70 percent cats.[5] Thus, human respiratory disease due to this organis alone or in combination probably is more frequent than recognized. Since the organism is very sensitive to penicilli it probably is treated without identification.

In the first case, the organism initially was misidentified *Acinetobacter calcoaciticus.* This possibility is we documented.[6-8] *Pasteurella multocida* is a small, nonmotil bipolar staining gram-negative rod that grows well in med containing blood. It can be confused with more common isolated bacteria including enterococci, *Neisseria,* an *Acinetobacter.*

The association of cirrhosis and *Pasteurella* septicemia in the second case has been previously documented.[9-11] B most of these patients had associated peritonitis and th various mechanisms leading to spontaneous bacterial per tonitis have been implicated.[12] Our patient does not fit th clinical picture.

SUMMARY

Pasteurella multocida infections can occur without a hi tory of animal bites. It has been postulated that infecte droplets could colonize the respiratory tract and lead t invasive disease in certain compromised patients. Our tw patients had bacteremia and empyema with this organis and responded well to therapy. Lung infections due t *Pasteurella multocida* probably are more common tha recognized.

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Education

DAVID I. CANAVAN, M.D., Lawrenceville*

The subject of education in the area of physician impairment has a broad range. It begins in medical school, carries throughout the practice years, and extends to the family, the hospital staff, and the governing board and to the allied health professionals who may work in close contact with the impaired physician or who may be impaired themselves.

This year marks the 30th anniversary of my graduation from one of the "top" medical schools in this country. In the four years I spent there, I cannot remember a single lecture on the subjects of alcoholism or drug addiction. We did learn about the effects of these diseases in some of our other courses. We were taught about cirrhosis, peripheral neuritis, delirium tremens, and Korsakow's psychosis in medicine and psychiatry. We also learned about bacterial endocarditis and hepatitis as serious threats to intravenous drug abusers. The surgeons taught us about bleeding varices but no one taught us about the diseases of substance abuse, i.e. alcoholism and drug abuse.

It became increasingly apparent to me that most of my fellow physicians were just as ignorant as I had been for this very same reason. The world's most sophisticated system of medical education "missed the boat" in preparing its students to understand, to accept, to recognize, and to treat the diseases of substance abuse. With the increasing enlightenment of society concerning these illnesses, one would expect that the medical education system would have recognized its responsibility to address these issues in a meaningful way in their curricula. Unfortunately, this has not been so in most schools. The young graduates of today are almost as poorly educated in this area as were their predecessors.

There has been some effort on the part of our New Jersey medical schools to increase the time allotted to alcoholism; this is especially true at Rutgers Medical School. A much more vigorous effort is needed to give appropriate time and effort to what is probably one of the most important public health concerns in this country today.

The Impaired Physicians Program is working with the faculties at the New Jersey medical schools to upgrade their programs and to fulfill their obligation to our students and their future patients.

The next area of concern in our educational endeavors has to do with the physicians in training and in practice.

We cannot ignore the large percentage of our physicians, already graduated, who missed out on adequate education in this area. It is essential that we continually reach out and attempt to provide them with the same basic information that we need to provide to our students.

This can be accomplished through articles, monographs, medical staff meetings, continuing education programs, county society meetings, The Academy of Medicine traveling symposia, and other teaching modalities.

The most difficult part of this task lies in convincing these physicians of their lack of adequate knowledge of these diseases and gaining their participation in our educational endeavors. Only dogged perseverance can succeed here. This same audience also must be confronted and brought up to date on the facts concerning the existence and frequency of these impairments within our own profession. Physicians are persons first and, as such, are subject to all of the ills of mankind.

Physicians must be taught about the existence of the Medical Society of New Jersey's Program for Impaired Physicians and they must be made to understand that our program is one of "tough love." It is directed at identification, treatment, and rehabilitation. It is not a disciplinary program.

There may be times when this "tough love" demands firmness and discipline, including temporary license suspension, but this usually is used only as a last resort to help accomplish the therapeutic goal.

We must teach peers, paraprofessionals, and hospital

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governing boards of their ethical and legal responsibility to assist in the identification of their impaired colleagues if we are to succeed with early intervention before significant and perhaps irreversible physical damage may have occurred to the physician, to say nothing of serious injury to patients and the physician's career.

Our educational responsibility extends into the physician's home. Just as the colleagues must know about the nature of impairment and the therapeutic resources available, the family requires similar education. Very often these are the worst "enablers." In their own loving concern they coverup. Sometimes because of their own shame or embarrassment, families share the physician's own denial and they shield the impaired physician from discovery. Family members need to be taught their options and the correct approach to their impaired family member.

Perhaps the best vehicle for this particular educational effort is the Medical Society of New Jersey Auxiliary. We have endeavored to bind the Auxiliary to us in this program in an enduring marriage of mutual concern for our fallen comrades who are their "loved ones" and our fellow physicians.

An additional area of concern in the education of the family involves the increasing evidence of the important role of heredity in addictive illness and mental disease. Over the 28 years that I have labored in this field the debate about "nature vs. nurture" has continued. In recent years there ha been an increasing amount of medical literature that give support to the concept that heredity is a major factor in th development of these diseases. Identical twin studies, adop tion studies, and even simple statistical reviews of th families of alcoholics and drug abusers demonstrate a ver significant increase in the incidence of substance abuse an what addictionologists refer to as the "addictive diseas personality." Dr. David Smith of the Haight-Ashbury Fre Medical Clinic in San Francisco, an outstanding authority i the field, is quoted in a recent *Newsweek* article (Decembe 13, 1982): "He has found, for example that the child of a alcoholic parent is 35 times more likely to become addicte himself—and that this figure soars to 400 if both parent were alcoholics."

These are the highest figures I have ever seen in referenc to relative incidence but they should serve to emphasize th strong influence that has been accorded to the role o heredity in these diseases.

Armed with this information we are committed to reac out to the families of our substance abusing colleagues an educate them about the role of heredity, the serious risk tha these diseases present to them, and the appropriate coun termeasures that they may employ.

Once again, this is an area where an enlightened an participating auxiliary can provide a real service.

Help for Impaired Physicians

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Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physician Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately, the psychopathy of substance abuse and addiction always gets worse while it is ignored.

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MEDICAL ETHICS

Withholding the Truth

RUSSELL L. McINTYRE, Th.D., Piscataway*

Telling the truth often is cited as a fundamental human obligation, especially in a free and democratic society. How can any community survive unless people agree to tell each other the truth, keep promises, and respect the sanctity of each other's life? Anomie, lawlessness, and anarchy quickly would result from the social and political rejection of such values.

In a one-to-one situation, however, medicine often has maintained a difference between general obligations that are necessary for the welfare of society and specific situations which may require the "bending" or withholding of the truth from a patient because a greater good would be served, namely protecting the patient from harmful or disastrous information about a medical condition. The Hippocratic oath contained no requirement for truthtelling, but only that the physician should do whatever "in his best judgment" was best for his patient. Indeed, a survey of physicians in Chicago in 1961 demonstrated a clear (90 percent) preference for not telling cancer patients that they had cancer or were dying from their disease.[1]

Since the early 1970s, a noticeable change has occurred in the preference of physicians regarding truthtelling. A similar survey of physicians in 1979 indicated that 97 percent of those surveyed expressed a preference for telling the truth to a patient who has cancer or who is dying.[2]

A number of factors might be involved, and not simply a more widespread recognition of the virtues of truthtelling. Among these must be: more knowledgeable patients, less fear of the diagnosis of cancer, and greater awareness of treatment modalities and of other patients who have survived both the disease and the treatment. On the part of physicians there must be: increased sensitivity to the needs of the patient who might want to "put his life in order," greater awareness of the techniques of truthtelling (e.g. over a period of time and not "the whole truth" in one fell swoop), and concern over culpability.

Arguments for benevolent deception, however, still emerge. Such arguments stress the difficult art of responsible decision making that always must remain the prerogative of the physician and which must not be replaced by legal requirement. One such argument appeared in *Newsweek* in 1979. Mack Lipkin, M.D., argued that: 1) telling the whole truth to a patient really is impossible because it is scientifically unknown; 2) it is absurd to communicate any knowledge as ultimate truth; 3) words, especially medical terms, have different meanings to laypeople and easily can increase their anxiety as they jump to wrong conclusions; and 4) the news of serious illness drives some patients to irrational and destructive behavior. Lipkin, therefore, argues strongly for benevolent deception with the only qualifying question focusing on "whether the deception is intended to benefit the patient or the doctor."[3]

Harvard ethicist, Sissela Bok, Ph.D., has become a voice for total honesty in the physician-patient encounter.[4,5] Arguing that the greatest agony of patients is to be in the "caring" hands of people they cannot trust, Bok stresses that deception, regardless of the motives, is destructive to all human relationships. Citing empirical studies that demonstrate that the overwhelming majority of people prefer to have honest information about their health, Bok believes there is no more justification for lying about medicine or medical care than there would be if the patient needed legal advice. From a practical concern she notes that patients bitterly resent being deceived if they find out; further, nurses resent having to take part in the deception. Bok concludes by proposing that "lying to a patient be regarded as serious as a breach of confidentiality."[5]

Benevolent deception has a strong rooting in paternalistic medical practice, as shown in the following section on the care of the terminally ill in a chapter entitled "Ethical Issues in Medical Practice" from a widely used textbook on primary care: "During the period of extremis, the physician automatically acquires as his patients the family members concerned with the welfare of the terminally ill individual. In these instances the family wishes to spare the patient discomfort but does not wish to be considered to have abandoned him or denied him anything that might have benefited him.

*Dr. McIntyre is Assistant Professor, UMDNJ-Rutgers Medical School, Piscataway. Correspondence may be addressed to Dr. McIntyre, UMDNJ-Rutgers Medical School, University Heights, Piscataway, NJ 08854.

The physician must deal with the concerns of the family, recognizing this ambivalence, and if he practices anti-dysthanasia [not allowing the patient to die a horrible death] for the comfort of the patient in extremis, it must be done in such a fashion that the family members feel assured that everything is being done that could be done to prolong life and attempt a cure."[6]

Note what is happening: as the physician begins withdrawing aggressive therapy—even life-supporting therapy—to allow the patient to die a more merciful death, the family is deceived into believing that everything still is being done to prolong life and attempt a cure. The result is that the patient dies and the family totally is unprepared. The death comes as a shock and, given the reaction of many families, they want to know "what went wrong?" Perhaps in their anger, they blame the medical and/or nursing staff for making a mistake.

"Deception, regardless of the motive, is destructive to all human relationships."

In the past several years, major changes have been taking place in the way in which the courts have regarded issues of truthtelling. Among the most noteworthy are the changes regarding the standards for informed consent. Two precedent-setting decisions are influencing statutory requirements and case-law decisions.[7,8] With regard to how informed the consent of a patient is, the older standard asked: "What do most physicians of that specialty (often, in that particular geographical area) tell patients with this particular problem?" The newer and developing standard focuses, rather, upon the question: "What does the patient need to know in order to make an informed and intelligent choice?" The physician-based standard is being replaced by the courts with the patient's right and need to know. Without this the assumption is that the consent might not be a truly informed decision.

With the focus now upon the patient's need to know, the issue of truthtelling in medicine—at least from the legal if not the ethical point of view—becomes clearer. Ethics stresses principles for right action; law prescribes rules for behavior. In truthtelling dilemmas, ethics recognizes that there might be a justifiable reason for withholding the truth from a patient, but even in ethics this ought to be the exception to the rule, not the rule itself. The physician's ethical judgment ought to be the standard, and, if this requires withholding the truth—or some of the truth—it must be supported (and documented in the patient's record), providing that the deception really is necessary for the best care of the patient and not just to benefit the convenience of the doctor or family. If the patient truly is the patient, then the first (but possibly not the only) consideration ought to be with the patient. If others are not able to share the truth, they may need additional counseling from you or someone else (psychiatrist, chaplain, or social workers).

We do our patients a disservice when we acquiesce to our own feelings of being uncomfortable with the truth being known or with the family's request to withhold the truth without examining their reasons with them. For most patients, with appropriate sensitivity to the style of our communication, the goal must be disclosure and the atmosphere one of openness and honesty. Anything else will diminish the trust of the physician-patient relationship and limit the effectiveness of the physician's ability to care.

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WHAT IS YOUR OPINION?*

Looking for Collar Buttons

SANFORD M. LEWIS, M.D., West Orange**

My eighth-grade teacher delighted in making her point obliquely. She apparently succeeded in assessing the sophistication level of her students, since I have never forgotten one of her lessons. It seemed, then, a hilarious story about a man who lost his collar button near the bed. When his wife found him searching near the window, she asked why. He answered, "The light's better over here."

Walter Sullivan, writer for *The New York Times,* described (November 2, 1982) the viral-genetic research of George J. Todaro, M.D., and Raoul E. Beneviste, M.D., of the National Cancer Institute's Laboratory of Viral Carcinogens in Maryland. The account stimulated conjecture about the direction in which we have been focusing our searchlights. A major question emerges. Is the migration of a virus from animal to animal a hitherto unrecognized form of reproduction rather that simply a type of infection? Have we stumbled upon a cosmic plan of miscegenation?

Physicians have wondered why so many viral "infections" are quite mild and of such brief duration as compared with those of bacterial or fungal or protozoan origin. Mild viral infections in pregnancy quite commonly produce severe birth defects whereas severe intrapartum bacterial infections do so rarely. Now, the researchers at the National Cancer Institute confirm the fact that viruses residing in one species can carry genetic material and invade individuals of an unrelated group in such manner as to induce genetic change, transmissible through ensuing host generations. The sudden gaps and rapid transmutations in an otherwise gradual and organized Darwinian evolutionary process have a new explanation.

As the bee migrates to ensure species preservation in the macroscopic sense, so does the sperm travel for a similar purpose on a microscopic level. Beyond this familiar mechanism, however, are we beginning to see the faint outlines of a bio-thrust aimed, not at a given species, but at all? Is this evolution's umbrella insurance policy extending the concept of survival of the fittest to survival overall through the far more rapid (re)production of new candidates for the race to eternity?

Perhaps we will find that the viral voyage is no more an infectious event than the better understood journey of the sperm. Perhaps neoplasia, so often associated in the laboratory with viral traces, is a corollary of this process with the rapid embryonic type of cellular growth leading aberrantly to disease rather than planfully to a new or transmuted species.

Are we really encountering yet another manifestation of the protean sexual drive capable of producing, just as in its more familiar form, the greatest rewards and the most profound tragedies of the biologic journey?

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*We encourage our readers to write opinions on topics of interest. Send your opinion to Editor, *The Journal,* MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

**Dr. Lewis is a member of our Essex County component. Correspondence may be addressed to Dr. Lewis, 50 Northfield Avenue, West Orange, NJ 07052.

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Offices To be Filled by Election 1983 Annual Meeting

ARMANDO F. GORACCI, M.D., Chairman

Office	Term	Nominee and County
President-Elect	1 year	Frank Y. Watson, M.D., Essex
1st Vice-President	1 year	Ralph J. Fioretti, M.D., Bergen
2nd Vice-President	1 year	Edward A. Schauer, M.D., Monmouth
Secretary	3 years	Arthur Bernstein, M.D., Essex
Treasurer	3 years	Paul J. Hirsch, M.D., Somerset
Trustees:		
1st District	3 years	Joel S. Cherashore, M.D., Essex
2nd District	3 years	Frank Gingerelli, M.D., Bergen
5th District	3 years	John J. Pastore, M.D., Cumberland
Judicial Councilors:		
2nd District	3 years	Robert A. Weinstein, M.D., Sussex
5th District	3 years	Ronald M. Fisher, M.D., Cumberland
AMA Delegates		
	½ year	*Howard D. Slobodien, M.D., Middlesex
	2 years	Howard D. Slobodien, M.D., Middlesex
	2 years	William J. D'Elia, M.D., Monmouth
	2 years	Myles C. Morrison, Jr., M.D., Morris
AMA Alternate Delegates		
	1½ years	Daniel J. O'Regan, M.D., Hudson
	2 years	Edward A. Schauer, M.D., Monmouth
	2 years	Augustus L. Baker, Jr., M.D., Morris
	2 years	James H. Spillane, M.D., Warren
	2 years	Frank Y. Watson, M.D., Essex

*If elected, vacancy will occur for unexpired term May, 1983, to December, 1983, as AMA Alternate Delegate. The ½-year term is being utilized to allow staggered tenure among the Delegation.

Office	Term	Nominee and County
Delegates and Alternate Delegates to Other States:		
New York:		
Delegate	1 year	F. Sterling Brown, M.D., Atlantic
Alternate	1 year	John J. Pastore, M.D., Cumberland
Connecticut:		
Delegate	1 year	Frank R. Romano, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
Administrative Councils:		
Legislation:		
1st District	3 years	Anthony P. Caggiano, Jr., M.D., Essex
4th District	3 years	Irving P. Ratner, M.D., Burlington
Medical Service:		
1st District	3 years	Richard H. Sharrett, M.D., Union
4th District	3 years	Lindsay L. Pratt, M.D., Camden
Mental Health:		
1st District	3 years	Alvin Friedland, M.D., Essex
2nd District	3 years	William H. Bristow, Jr., M.D., Bergen
Public Health:		
6th Member	1 year	Glenn P. Lambert, M.D., Hunterdon
1st District	3 years	Edward M. Coe, M.D., Union
4th District	3 years	William Pawluk, M.D., Burlington
Public Relations:		
1st District	3 years	Robert J. Lorello, M.D., Essex
4th District	3 years	Jesse Schulman, M.D., Ocean
Standing Committees:		
Annual Meeting	3 years	John F. Marshall, M.D., Mercer
Auxiliary Advisory	3 years	George T. Hare, M.D., Camden
Finance and Budget	3 years	B. Ralph Wayman, Jr., M.D., Mercer
Medical Defense & Insurance	3 years	Carl A. Restivo, Jr., M.D., Hudson
Medical Education	3 years	Roberta G. Rubin, M.D., Passaic
Publication	3 years	Frederick B. Cohen, M.D., Essex

Trustees' Minutes January 16, 1983

A regular meeting of the Board of Trustees was held on Sunday, January 16, 1983, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Report of the President . . .

(1) JCAH Accreditation Manual for Hospitals . . . Approved the recommendations on the proposed revisions to the medical staff section of the *Accreditation Manual for Hospitals.*

(2) AMA State Health Legislation Meeting . . . Received a report from Doctor Slobodien on his attendance at the AMA Conference on State Medical Society Legislation.

(a) Legislative Advisory Committee . . . Dr. Slobodien will suggest that the Council on Legislation consider the concept of developing a mechanism for monitoring legislative activities of the state and county societies similar to the committee and subcommittee structure of the Medical and Chirurgical Faculty of the state of Maryland.

(b) Political Action Committee . . . Doctor Slobodien will recommend to JEMPAC that the committee explore the candidates being supported by MSNJ, including their voting records, committee chairman positions, political trends, electability, and availability to physicians.

(c) Biomedical Ethics . . . Doctor Slobodien suggested that the final report of the President's Commission on Biomedical Ethics be obtained for MSNJ.

(3) New Jersey State Commission on Cancer Research . . . Received as informative a communication from the Institute for Medical Research listing the Institute's five nominees for appointment by Governor Kean to the Commission. Also, authorized the President to submit to Governor Kean the names of nominees for appointment as MSNJ's representatives to the Commission.

Report of the Executive Director . . .

(1) MSNJ Paid Membership . . . Noted that as of December 31 total paid membership is 46 members fewer than in 1981. Also, as of January 10, 1983, 1983 dues had been received for 4,185 members (an increase of 339 members from January 31, 1982).

(2) County Comparison 1982 to 1981 Paid Membership . . . Noted county membership figures. Also, an experimental program designed as an incentive for counties to become more active in membership recruitment will be initiated in June, 1983. Counties exceeding their 1982 dues-paid membership at that time will be notified that they are eligible for a 50 percent discount on the dues allocated to the State Society for each new member joining MSNJ after the goal is met.

(3) Review of December 31, 1982, Financial Statements . . . Reviewed and approved the financial statements for the period ending December 31, 1982.

(4) Legal Matters . . .

(a) State Board of Medical Examiners vs. Greco . . . Noted that the request of MSNJ to appear amicus curiae before the State Board of Medical Examiners was denied. Noted that the State Board issued a one-year suspension of license (with probation) and assessed a fine against Doctor Greco.

(b) State Board Determination on Physical Therapy Services . . . Noted that the State Board of Medical Examiners questioned the propriety of the determination that physical therapists may accept referrals from chiropractors and voted to reconsider the matter.

(c) Subordinated Loan Deductibility . . . Noted that the Tax Court has appointed a special trial judge for the case who will submit his report to the Tax Court; the trial should be held soon.

(5) Meeting with Blue Shield Executive Committee . . . Noted that the Board opposed a new program developed by Blue Shield called PACE. Directed the President and the Executive Director to develop an effective means to support the Board's position.

Note: In April, Blue Shield plans to market four performance and cost effectiveness (PACE) programs that will include a different schedule of payments for participating, as opposed to nonparticipating, physicians.

(6) Legislation—S-1919 . . . Noted active opposition to this bill that calls for the merger of the Department of Health and the Department of Human Services; in the merger, the post of Commissioner of Health would be eradicated and the Commissioner of Human Services would assume the title of Commissioner of the new Department of Health and Human Services.

(7) Commissioner of Health . . . Directed that a communication be sent to Governor Kean requesting that a Commissioner of Health be appointed as soon as possible and reiterating the Board's endorsement of the requirement that the Commissioner of Health be a physician.

University of Medicine and Dentistry . . .

Fifth Pathway . . . Noted that the Fifth Pathway Program will be terminated at the end of the 1983-1984 school year.

New Jersey Political Action Committee . . . Approved the following recommendation:

That the Board of Trustees approve the following newly appointed and reappointed members to the JEMPAC Board of Directors: John W. Holdcraft, M.D., 1st Congressional District; Jeffrey M. Solomon, M.D., 2nd Congressional District; Edward A. Schauer, M.D., 3rd Congressional District; Karl T. Franzoni, M.D., 4th Congressional District; Hormoz M. Minoui, M.D., 5th Congressional District; Norval F. Kemp, M.D., 6th Congressional District; Frank Romano, M.D., 7th Congressional District; Edward W. Luka, M.D., 8th Congressional District; Harold L. Scales, M.D., 9th Congressional District; Anthony P. Caggiano, Jr., M.D., 10th Congressional District; Charles H. Arnoldi, Jr., M.D., 11th Congressional District; Robert J. Weierman, M.D., 12th Congressional District; Harold L. Colburn, Jr., M.D., 13th Congressional District; and Thomas J. Connolly, Jr., M.D., 14th Congressional District; and members at large: Mr. Joseph Klein, Auxiliary Liaison; George L. Triebenbacher, M.D.; William Ryan, M.D., Chairman; Robert S. Rigolosi, M.D.; and Stanley Brestticker, M.D., President, New Jersey Association of Medical Speciality Societies.

New Jersey Hospital Association . . .

(1) DRG Hearing . . . Noted that the Hospital Association will present testimony before the Senate Subcommitttee on Health in Washington, D.C.

(2) Uniform Determination of Death Act (S-1400) . . . Noted that Doctor Slobodien will meet with representatives of the

NJHA Council on Government Relations to discuss this bill.

Committee on Impaired Physicians . . . (1) Structure of the Committee . . . Approved the following recommendations:

(1) That the Board of Trustees of MSNJ approve the restructure of the Committee on Impaired Physicians into two sections: (a) a Panel of Intervenors/Monitors; and (b) an Executive Subcommittee. With membership, duties, and meeting schedules as outlined in the presentation.

(2) That, because of the unusual nature of this Committee and the combined involvement of the New Jersey Association of Osteopathic Physicians and Surgeons, the Auxiliaries, the various specialty societies, and MSNJ, the Committee on Impaired Physicians be considered a special committee in which active membership in MSNJ is not a prerequisite for committee membership.

(3) That the President of MSNJ approve the slate of nominees for membership on the Executive Subcommittee of the Impaired Physicians Program as indicated above for a term of three years. (Please note: It is not the intention of the Committee to limit future membership from the specialty societies to that person holding the office of president. Likewise, membership from the Committee on Drug and Alchohol Abuse should not be limited to the individual holding the chairmanship.)

(4) That the Board of Trustees endorse the use of a conference call by the Executive Subcommittee and the Board of Trustees in emergency situations.

(5) That a quorum for regular meetings of the Executive Subcommittee will require two-thirds of the members of the Executive Subcommittee.

(2) Guidelines for Optimal Handling of Chemically Impaired Physicians in a Hospital Setting . . . Approved the following recommendation:

That the Board of Trustees endorse "Guidelines for Optimal Handling of Chemically Impaired Physicians in a Hospital Setting." (Copies are available at the Executive Offices)

Impaired Physicians Program . . . Received with commendation a written report from David I. Canavan, M.D., Medical Director of the Impaired Physicians Program, outlining activities for the past month.

Committee on Medicaid . . . (1) Reimbursement for the Cost of Immunization Under the Medicaid Program . . . Approved the following recommendation:

That the Board of Trustees forward a letter to the Governor, with copies to the Commissioner of Human Services, the State Attorney General, and the Surgeon General of the United States indicating that the issue of reimbursement for the cost of immunizations under the Medicaid Program has not yet been resolved. It also is recommended that the Governor be supplied with the October 21, 1982, letter from the New Jersey Chapter of the American Academy of Pediatrics.

(2) NJ Medicaid Competition Demonstration Project—Medicaid Family Health Plan . . . Will ask the Committee on Medicaid to present its recommendations on the New Jersey Medicaid Competition Demonstration Project in February.

Note: The Demonstration will, on a voluntary participation basis for providers and Medicaid eligibles, allow eligible households to select a provider as a case manager, for primary care delivery, referrals, and ancillary services for noninstitutional recipients. The goal of the project is to reduce costs, to improve quality of health care, and to demonstrate the effectiveness of the competition approach.

State Board of Medical Examiners . . . Noted the following items: Doctor Joseph A. Riggs will represent SBME at the next medicolegal seminar of MSNJ; Doctor Floyd J. Donahue was appointed to chair the Physical Therapy Excessive Fee Committee; a ruling was made regarding the ability of physical therapists to accept written prescriptions from out-of-state licensed physicians; Doctor Edwin H. Albano made a statement regarding a solicitation letter for prepaid insurance for lawyer representation at informal hearings before the SBME. Doctor Slobodien indicated he would respond to Doctor Albano.

Voted to send a letter to the SBME requesting a designated representative to attend MSNJ Board meetings and act as a liaison during interim points in an effort to improve communication between the SBME and MSNJ. Requested a report regarding the caseload under the Legal Services Plan, as well as the volume of telephone calls, communications, and hours spent in service to the Legal Services Plan. Requested the Committee on Medical Defense and Insurance to evaluate the Legal Services Plan and alternate concepts.

Old Business . . .

Appointment of a Limited Guardian for Certain Persons Exposed to Coercive Persuasion . . . Postponed consideration of bills **S-488** and **A-1087** because of lack of time.

Note: Doctor Harold Scales asked the Board to reconsider its previous action on **S-488** and **A-1087.**

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

Although we already are several months into the new year of 1983, the old year of 1982 was a period of such significant development for the University of Medicine and Dentistry of New Jersey that reviewing some of the major events is appropriate.

UMDNJ made important advances last year in strengthening the University as an institution, in knowledge of disease and injury and how to treat them, and in the delivery of health services and information.

Often, of course, a single development affects all three areas. The multidisciplinary, innovative Pain Center established last year on the Newark campus, for example, provides direct relief to acute and chronic pain sufferers, looks for better ways to control pain, and strengthens UMDNJ in its endeavor to provide highly specialized services to the state.

The new Center for Human Molecular Genetics just recently has been established at the Piscataway campus by some of the world's foremost specialists in the field of collagen research and diseases of the bones and connective tissue.

The University's new Cancer Research and Treatment Center, for which ground was broken last April on the Newark campus, will treat patients—direct radiation of surgically exposed tumors being one technique available—and buttress cancer research already in progress.

With the New Jersey Department of Defense and National Guard, UMDNJ last year agreed to develop a plan for a 250-bed hospital for use in the event of civilian or military emergency.

In the field of medical advances, UMDNJ passed a notable milestone in 1982 by obtaining its first patent—awarded to a four-member orthopedics research team at UMDNJ-New Jersey Medical School for a carbon fiber implant that permits regenerative repair of tendons and ligaments.

Other progress in medical knowledge at UMDNJ last year included discovery of the complete similarity of leprosy in humans and armadillos, which is expected to help in finding a vaccine for that stigmatizing disease; a computerized electronic system for monitoring blood flow that may permit painless and speedier diagnosis of heart disease; and the identification of a hereditary

enzyme deficiency which causes symptoms resembling Parkinson's disease and may be treatable by changes in diet.

The finding that regular exercise reduces the risk of atherosclerosis among male diabetics led to a UMDNJ-Rutgers Medical School project promising better health for participants through a comprehensive program of nutrition, lifestyle modification, and exercise.

In the delivery of health care, UMDNJ embarked on a $3 million expansion of the AHEC (Area Health Education Center) program, launched in 1980 in Camden under direction of UMDNJ-New Jersey School of Osteopathic Medicine, to serve seven more southern New Jersey counties. The two new AHEC programs are based at the Atlantic City Medical Center and Bridgeton Hospital.

A four-year project is underway at the Piscataway campus to establish a comprehensive regional service system for developmentally disabled children in central New Jersey. The project, aimed at coordinating a widespread network of special services, gained an $800,000 grant from the Robert Wood Johnson Foundation.

UMDNJ helped to spread knowledge about health problems with major conferences on home health care and on gambling, and by reporting on participation at the Newark and Piscataway campuses in the National Institutes of Health (NIH) Multiple Risk Factor Intervention Trial (popularly known as Mr. Fit), which endeavored to learn whether middle-aged men could reduce the risk of heart failure by reducing their smoking, high blood pressure, and cholesterol levels.

MSNJ Auxiliary

Linda B. Hirsch
President

Stress occurs in our lives when we are children, adolescents, and young and aging adults. What are the symptoms of stress, the causes, and the cures, if any? Attend the "Seminar on Stress," on Saturday, April 30, 1983, at 2:00 P.M., in the Viking Room, 13th floor, Resorts International Hotel, Atlantic City. The Medical Society of New Jersey Auxiliary is sponsoring this important program during the Annual Meeting, where prominent experts will speak.

George F. Wilson, M.D., president and chief executive officer, Carrier Foundation, will moderate the seminar. Diane Shrier, M.D., chief of child psychiatry at the University of Medicine and Dentistry of New Jersey, will discuss stress during childhood years. Adolescent problems will be presented by Dr. Morton Wolitzer, a school psychologist from New York. Stress during adulthood is the topic of Mrs. Patricia Miller, a marriage counselor with Family Counseling Service of Somerset County. Mr. David Williams, who teaches a college course, "My Aging Parents and Me," will speak on the problematic issues. A panel discussion will follow the speakers' presentations.

This seminar will be approved for Category I CME credit.

New Members

The Journal would like to welcome these new members to the Medical Society of New Jersey.

Atlantic County
Leonard Galler, M.D., Somers Point

Bergen County
John Sarokhan, M.D., Ridgewood

Burlington County
Jonathan R. Anolik, M.D., Mount Laurel
Samir B. Botros, M.D., Browns Mills
Renato J. Briones, M.D., Mount Holly
Kelly D. Fife, M.D., Moorestown
John D. Gallagher, M.D., Browns Mills
Sneh Jain, M.D., Mount Laurel
Stephen A. Rafelson, M.D., Mount Laurel
Richard G. Tucker, D.O., Mount Laurel
Peter E. Turner, M.D., Browns Mills

Camden County
Terry D. Friedman, M.D., Haddonfield
Andrew C. Greene, M.D., Cherry Hill
Irwin L. Lifrak, M.D., Camden
Ronald Rahman, M.D., Camden
Shekeeb Sufian, M.D., Stratford

Essex County
Lloyd H. Alterman, M.D., Livingston
Michael J. Brien, M.D., Montclair
Jewell L. Daniels, Jr., M.D., East Orange
Mahesh R. Deasi, M.D., Irvington
Reynaldo S. DeCastro, M.D., Bronx, NY
John A. Di Filippo, M.D., Glen Ridge
Ralph M. Eastman, M.D., Livingston
Ludivina S. Joaquin, M.D., Newark
Anthony A. Losardo, M.D., Belleville
Michael C. Milano, M.D., Glen Ridge
Jacob Offenberger, M.D., Newark
David Mark Richmand, M.D., Irvington
James A. Rommer, M.D., Irvington
Stephen Sadow, M.D., Dover
Nasier B. Soliman, M.D., Newark

Gloucester County
Francis T. Ferry, M.D., Woodbury Heights

Hudson County
Muhammad A. Ahmad, M.D., Jersey City
Hugo R. Basterrechea, M.D., West New York
James A. Charles, M.D., Bayonne
Doris M. Delgado, M.D., West New York
Louis J. Di Bella, Jr., M.D., Union City
Paul A. Foddai, M.D., Jersey City
Hugo D. Kitzis, M.D., West New York
Agustin G. Latorre, M.D., Union City
Manuel O. Mendoza, M.D., Union City
John N. Mifsudo, M.D., Union City
Issam Mouded, M.D., Union City
Rose L. Oen, M.D., Bayonne
Anthony L. Panariello, M.D., Jersey City
Lerma E. Retuta, M.D., Jersey City
Felix Sesin, M.D., West New York
Yale C. Shulman, M.D., Jersey City
Anangur P. Swaminathan, M.D., Jersey City
Edmund C. Topilow, M.D., Bayonne
Frederick J. Weisbrot, M.D., Kearny
Kanagarayer R. Wignarajan, M.D., Bayonne

Middlesex County
Karen McK. Ingram, M.D., Franklin Park
Jeffrey L. Kaufman, M.D., Highland Park
David M. Mac Peek, M.D., Highland Park
Howard W. Rosenblum, M.D., Edison
William H. Rossy, M.D., Metuchen
Matthew J. Speesler, M.D., North Brunswick
Alfred F. Tallia, M.D., New Brunswick
Elie Younes, M.D., South Amboy

Monmouth County
Charles E. Brancato, M.D., Middletown
Robert L. Gabel, M.D., Red Bank
Arnold M. Grebler, M.D., Long Branch
Chi Yeung Lau, M.D., Wall

Morris County
George Babcock, Jr., M.D., Kinnelon
William K. Cors, M.D., Denville
Mark S. Diamond, M.D., Morristown
Ronald H. DuBow, M.D., Budd Lake
Steven M. Gudis, M.D., Randolph
Paul C. Lam, M.D., Denville
Leon H. Waller, D.O., Boonton

Ocean County
Gregory M. Borsuk, M.D., Toms River
Robert E. Schnitzer, M.D., Toms River

Passaic County
Fouad Hanna Abdelsayed, M.D., Paterson
Howard B. Baum, M.D., Paterson
Hamilton C. Goulart, M.D., Fair Lawn
Thomas M. Herskovic, M.D., Paterson
John I. Sutter, M.D., Clifton
Mohammad Zamani, M.D., Passaic

Somerset County
Zafar A. Shaheen, M.D., Middlesex

Union County
Raymond Alexander, M.D., Elizabeth
Margaret M. Bouffard, M.D., Warren
Sheila E. Buckbinder, M.D., Westfield
Peter F. Cheung, M.D., Highland Park
John F. Elenewski, M.D., Cherry Hill
Joseph W. Keyser, M.D., Summit
Thomas P. Lewis, M.D., Plainfield
David R. Lingelbach, M.D., Plainfield
Jack H. Ostroff, M.D., Plainfield
John F. Tabachnick, M.D., Westfield
Albert B. Thrower, M.D., Westfield
Benjamin O. Zamora, M.D., Elizabeth

Finding Additional Physicians*

Despite recent increases in the number of practicing physicians, there are areas of the country considered physician-shortage areas because there are not enough physicians for the population or

*From the Department of Health Care Resources, American Medical Association, 535 North Dearborn Street, Chicago, IL 60610.

perhaps no physicians at all. In such areas—which often are in rural communities, but which also can be found in certain urban or metropolitan centers—the population does not have adequate access to medical care and their medical needs are not being met.

At the same time, this situation is a hardship for the physicians who already are practicing in such areas. They often are in practices that are overcrowded and understaffed and with no help in sight. Another common problem, especially in rural areas, concerns the retiring physician who has built up a thriving practice but who is unable to locate a physician willing to take it over. These physicians cannot help but wonder at the scenario of too many physicians.

If you are such a physician, you probably are looking for new ways to attract another physician to your community or practice. This is not always an easy task, especially in the more rural areas. But there are ways it can be done. Many of these underserved communities are not depressed economically and could support a private practitioner. Frequently, they just need assistance in reaching the right physician audience.

How does one attract a new physician to such a community? There are several ways. The American Medical Association (AMA) Physician Placement Service, as well as those operated by many state medical associations and medical specialty societies, have proved very effective, although not always in the most physician-short areas of the country. In addition, many state governments have developed incentive programs for physicians to train and practice in their states. Some allow the community or practicing physician to "sponsor" a new physician through the state.

How does it work? Each year new physicians became available whose training has been financed through the NHSC scholarship program. In return for these scholarships, the physicians agree to practice for a period of time in a federally-designated Health Manpower Shortage Area (HMSA). Under the Private Practice Option, these physicians now can fulfill their obligations in the private sector if they establish a private practice in a Health Manpower Shortage Area; they can locate outside of the HMSA if 80 percent of their patients are from a nearby HMSA.

The Private Practice Option is gaining increasing favor among the NHSC physicians. Last year, over 400 physicians took the Option and it is anticipated that more will do so in the next few years. For the most part, these young physicians are anxious to establish a permanent practice and to become a part of the community. They see the Private Practice Option as an opportunity to begin their practices without further delay.

The HMSA-located communities benefit as well. Many of them have been unable to attract a physician and now have an opportunity to do so through the Private Practice Option. The physician's scholarship obligation may lead him to consider a practice opportunity that he may have ignored under other circumstances. And once established in a suitable private practice, the physician will be more likely to stay.

The American Medical Association supports the Private Practice Option approach and has agreed to assist the National Health Service Corps by contacting communities and physician practices in Health Manpower Shortage Areas who are seeking additional physician manpower. The potential sites, if appropriate in terms of need and professional and community support, are then referred to the NHSC-obligated physicians for their consideration.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGIES—Robert M. Klein, M.D., 5959 Delafield Ave., Riverdale, NY 10471. New York Medical College 1976. Subspecialty, pediatrics. Board certified, pediatrics; board eligible, immunology/allergy. Single or multispecialty group, partnership, solo, institutional. Available July 1984.

ANESTHESIOLOGY—Bert Guajardo, M.D., 7907 Belle Park Dr., Houston, TX 77072. Creighton 1979. Board eligible. Group or partnership. Available.

FAMILY MEDICINE—David Kaufman, M.D., 70 Lancaster Rd., West Hartford, CT 06119. St. Louis 1975. Board certified. Partnership or group. Available July 1983.

Max Burger, M.D., 11 West 69th St., New York, NY 10023. Royal College of Surgeons (Ireland) 1976. Board certified. Group, HMO, partnership. Available.

GASTROENTEROLOGY—William W. Mark, Jr., M.D., 2289 South Lewiston St., Aurora, CO 80013. Guadalajara (Mexico) 1975. Also, general internal medicine. Group or partnership. Available June 1983.

Leonard Luterman, M.D., 5740 Cavendish Blvd., Apt. 1308, Montreal, Quebec, Canada H4W 2T8. McGill 1977. Also, general internal medicine. Board eligible. Any type practice. Available July 1983.

Louis D. May, M.D., 2122 Kensington Ave., Salt Lake City, UT 84108. Miami 1978. Also, general internal medicine. Board certified (IM). Group or partnership. Available June 1983.

Satya V. Jayanty, M.D., 131 Breckinridge Square, Louisville, KY 40220. Andhra (India) 1974. Also, general internal medicine. Board certified (IM). Partnership. Available July 1983.

N.P. Narayana, M.D., 31 Minebrook Rd., Apt. 169-B, Edison, NJ 08820. Mysore (India) 1971. Also, general internal medicine. Board certified (IM). Partnership, solo, group. Available July 1983.

GENERAL PRACTICE—Alan D. Brownfield Palo, M.D., 6611 Pelham Dr., Parma, OH 44129. Guadalajara (Mexico) 1976. Special interest in ENT. Office-based general ENT, surgical ER, surgical house staff. Available.

Jayen C. Shah, M.D., 4848 North Kimball, Apt. 2-N, Chicago, IL 60625. Baroda (India) 1974. Also, emergency room medicine. Group, partnership, solo. Available.

Mustafa Boyer, M.D., 168 S. Kentucky Ave., Atlantic City, NJ 08401. Istanbul (Turkey) 1943. Partnership, nursing home, hospital house physician. Available.

INTERNAL MEDICINE—William W. Mark, Jr., M.D., 2289 South Lewiston St., Aurora, CO 80013. Guadalajara (Mexico) 1975. Subspecialty, gastroenterology. Group or partnership. Available June 1983.

Laurence N. Sechter, M.D., 1870 Stewart Ave., New Hyde Park, NY 11040. Rome (Italy) 1977. Subspecialty, nephrology. Board eligible. Partnership, solo, group. Available July 1983.

Young J. Ko, M.D., 2927 Dorchester St., Apt. 206, Troy, MI 48084. Chonnam (Korea) 1973. Subspecialty, pulmonary medicine. Board certified (IM); board eligible (PM). Solo, group, partnership. Available July 1983.

Frank Lopez, M.D., 60 Overlook Rd., Summit, NJ 07901. Einstein 1980. Board eligible. Group or partnership. Available.

Louis D. May, M.D., 2122 Kensington Ave., Salt Lake City, UT 84108. Miami 1978. Subspecialty, gastroenterology. Board certified. Group or partnership. Available June 1983.

Leonard Luterman, M.D., 5740 Cavendish Blvd., Apt. 1308, Montreal, Quebec, Canada H4W 2T8. McGill 1977. Subspecialty, gastroenterology. Board eligible. Any type practice. Available July 1983.

M. Zaslow, M.D., 24 Westgate Road, Chestnut Hill, MA 02167. Harvard 1977. Subspecialty, pulmonary medicine. Board certified (IM); board eligible (PM). Any type practice. Available.

David George, M.D., 76 St. Paul Street, Apt. 6, Brookline, MA 02146. Harvard 1978. Subspecialty, rheumatology. Board certified. Group. Available July 1983.

Arthur C. Tutela, M.D., 132 Midland Place, Newark, NJ 07106. Bologna (Italy) 1974. Also, general medicine. Group, partnership, clinic, institution. Available.

Andrew Stolzar, M.D., 3 Petunia Drive, Apt. 2-C, North Brunswick, NJ 08902. Graz (Austria) 1979. Board eligible. Group or partnership. Available July 1983.

Richard M. Moccia, M.D., 10 Loden Lane, Rochester, NY 14620. Dartmouth 1977. Also, gastroenterology. Board certified (IM); board eligible (gastroenterology). Solo, group, partnership, hospital-based practice combining IM and consultative GI. Available June 1983.

Dennis Parenti, M.D., 131-F Marina Drive, Edison, NJ 08817. Washington University 1978. Subspecialty, rheumatology. Board certified (IM); board eligible (rheumatology). Partnership or group. Available July 1983.

Robert M. Lintz, M.D., 80 High St., Apt. 21-B, Dedham, MA. Jefferson 1978. Subspecialty, gastroenterology. Board certified. Group, partnership, solo. Available.

Stewart A. Robbins, M.D., 73-11 210th Street, Apt. 2-K, Bayside, NY 11364. SUNY-Downstate 1978. Subspecialty, gastroenterology. Board certified. Group or partnership. Available July 1983.

Mel Kaplan, M.D., 48 Medinah Drive, Reading, PA 19607. New York University 1976. Board certified. Any type practice. Available.

Viswanath P. Vasudevan, M.D., 59-21 Calloway St., Apt. 5-L, Corona, NY 11368. Bombay (India) 1976. Subspecialty, pulmonary medicine. Board certified. Group or solo. Available July 1983.

Khalid I. Khan, M.D., 3317 Old Church Rd., Augusta, GA 30907. Khyber (Pakistan) 1975. Subspecialty, pulmonary medicine. Board eligible. Group or partnership. Available July 1983.

N.P. Narayana, M.D., 31 Minebrook Rd., Apt. 169-B, Edison, NJ 08820. Mysore (India) 1971. Also, general internal medicine. Board certified (IM). Partnership, solo, group. Available July 1983.

NEPHROLOGY—Carl S. Goldstein, M.D., 860 Gates Pavilion, 3400 Spruce St., Philadelphia, PA 19104. Washington University 1978. Also, general internal medicine. Board certified (IM). Group or partnership. Available July 1983.

OBSTETRICS/GYNECOLOGY—Francine A. Guzman, M.D., 132-17 58th Road, Flushing, NY 11355. New York Medical 1979. Board eligible. Group or partnership. Available June 1983.

Ho Young Kim, M.D., 1945 Corlies Avenue, Neptune, NJ 07753. Chonnam (Korea) 1972. Board eligible. Solo, group, partnership. Available July 1983.

OPHTHALMOLOGY—Michael Hostovsky, M.D., 4100 West 36th St., Minneapolis, MN 55416. Hadassah (Israel) 1972. Also, neuro-ophthalmology. Board eligible. Single or multispecialty group. Available.

Jasvinder Singh, M.D., 500 Central Ave., Apt. 702, Union City, NJ 07087. Lady Hardinge (India) 1970. Board eligible. Partnership, group, HMO. Available.

OTOLARYNGOLOGY—Richard Schiffman, M.D., 2717 East 28th St., Brooklyn, NY 11235. Tufts 1977. Board eligible. Partnership or group. Available.

Kwang H. Choi, M.D., 8704 Pellington Place, Apt. 3, Richmond, VA 23229. Seoul (Korea) 1976. Board eligible. Partnership or associates. Available July 1983.

Bruce Grossman, M.D., 215 East Chicago Ave., Apt. 1101, Chicago, IL 60611. Illinois 1978. Board eligible. Group or partnership. Available July 1983.

PATHOLOGY—Siamak Shokri-Tabibzadeh, M.D., Montefiore Hospital and Medical Center, 111 E. 210th St., Bronx, NY 10467. Tehran (Iran) 1977. Academic institution. Available.

Marvin N. Solomon, M.D., 3 Sutliff Ave., Vineland, NJ 08360. Berne (Switzerland) 1937. Special interest in anatomic and forensic. Board certified (PA); board eligible (forensic). Hospital staff, locum tenens. Available.

Pushpa Gupta, M.D., 100-C Thorndale Dr., Dayton, OH 45429. Dr. S.N. Medical College (India) 1971. Any type practice. Available.

PEDIATRICS—Shailesh J. Shah, M.D., 430 E. 67th St., Apt. 5-C, New York, NY 10021. Baroda (India) 1974. Board eligible. Special interest in pediatric hematology/oncology. Group, partnership, institutional. Available July 1983.

Renuka D. Desai, M.D., 1258 Liberty Bell Dr., Cherry Hill, NJ 08003. GS Medical College (India) 1973. Board certified. Group or partnership. Available.

Ann M. Hawryluk, M.D., 1804 Windsor

217th Annual Meeting
April 29–May 2, 1983

Resorts International
Atlantic City, New Jersey

Daily Schedule

Friday, April 29, 1983

3:30 p.m.—Board of Trustees' Meeting
5:00 p.m.—Delegate Registration
7:00 p.m.—Officers' Cocktail Reception followed by Dinner

Saturday, April 30, 1983

7:30 a.m.—Delegate Registration
9:00 a.m.—House of Delegates
9:00 a.m.—Message Center, Scientific, Informational, and Insurance Exhibits Open
10:30 a.m.—House of Delegates (election)
12:00 noon—Golden Merit Award Ceremony followed by Reception
1:00 p.m.—Reference Committee Meetings
5:00 p.m.—JEMPAC Political Forum
5:45 p.m.—JEMPAC Wine and Cheese Reception

Sunday, May 1, 1983

8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—Scientific Sessions
12:00 noon—Luncheons
1:00 p.m.—Scientific Sessions
6:30 p.m.—Inaugural Reception followed by Inaugural Dinner

Monday, May 2, 1983

6:30 a.m.—County Society Breakfast Caucuses
8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—House of Delegates
12:00 noon—Message Center, Scientific, Informational, and Insurance Exhibits Close
12:00 noon—House Adjourns for Lunch
1:30 p.m.—House Reconvenes
3:00 p.m.—Board of Trustees' Meeting

Ridge Dr., Westborough, MA 01581. Harvard 1980. Board eligible. Group, partnership, HMO, solo. Available July 1983.

Edgar C. Orate, M.D., 1945 Corlies Ave., Neptune, NJ 07753. University of the East (Philippines) 1978. Board eligible. Group, partnership, solo. Available July 1983.

Alan M. Muney, M.D., 2353 Moreno Drive, Los Angeles, CA 90039. Brown 1978. Board eligible. Group or partnership. Available.

PSYCHIATRY—Paul L. Maitheny, M.D., 99 Pawnee Rd., Lakewood, NJ 08701. University of Graz (Austria) 1951. Board eligible. Available.

PULMONARY DISEASES—Young J. Ko, M.D., 2927 Dorchester St., Apt. 206, Troy, MI 48084. Chonnam (Korea) 1973. Also, general internal medicine. Board certified (IM); board eligible (PM). Solo, group, partnership. Available July 1983.

M. Zaslow, M.D., 24 Westgate Road, Chestnut Hill, MA 02167. Harvard 1977. Also, general internal medicine. Board certified (IM); board eligible (PM). Any type practice. Available.

RADIOLOGY (DIAGNOSTIC)—Kailash Tarneja, M.D., 8710-A Park Crestwood Drive, Crestwood, MO 63126. Delhi (India) 1974. Board eligible. Group, partnership, solo. Available.

Michael M. Abiri, M.D., 1077 River Road, Edgewater, NJ 07020. Tehran (Iran) 1972. Board certified. Any type practice. Available April 1983.

RHEUMATOLOGY—David George, M.D., 76 St. Paul St., Apt. 6, Brookline, MA 02146. Harvard 1978. Also, general internal medicine. Board certified (IM). Group. Available July 1983.

SURGERY, GENERAL—James P. Gadzik, M.D., 414 Country Lane, Narberth, PA 19072. Pennsylvania 1976. Group, partnership, general surgery (with vascular and thoracic). Available July 1983.

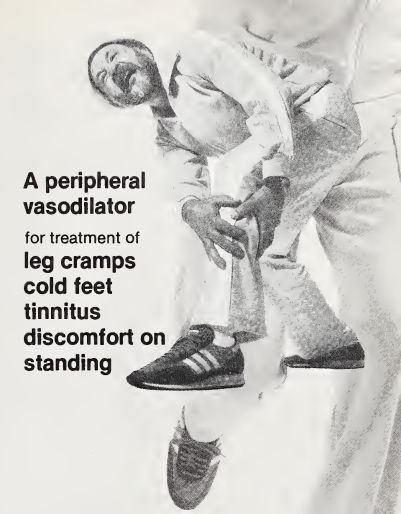
SURGERY, ORTHOPEDIC—Shearwood J. McClelland, M.D., 380 E. Town St., Columbus, OH 43215. Columbia 1974. Board certified. Partnership or group. Available.

SURGERY, THORACIC—John P. Hubert, Jr., M.D., 33 Viking Village, N.W., Rochester, MN 55901. Minnesota 1975. Board certified. Private practice, single specialty in small group. Available July 1983.

SURGERY, VASCULAR—John P. Hubert, Jr., M.D., 33 Viking Village, N.W., Rochester, MN 55901. Minnesota 1975. Board certified. Private practice, single specialty in small group. Available July 1983.

UROLOGY—Howard L. Frey, M.D., 10982 Roebling Ave., Apt. 425, Los Angeles, CA 90024. Johns Hopkins 1977. Subspecialty, infertility and microsurgery. Board eligible. Group, partnership, solo. Available July 1983.

Marc Nierman, M.D., 14 Jennings Rd., Waltham, MD 02154. Wisconsin 1978. Board eligible. Group or partnership. Available July 1983.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
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discomfort on standing

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AVAILABLE: Bottles of 100, 500.

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LIPO-NICIN®/250 mg.
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Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
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Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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REFER TO PDR

MEDICAL PHILATELY

Modern Medicine

JOSEPH H. KLER, M.D., New Brunswick

Charles Richard Drew, M.D., (1904–1950) was born in Washington, DC. During his four years at Amherst, he was a star in track and football. He received his medical degree and master of surgery degree in 1933 from McGill Medical School, Canada, and spent two years as an intern and resident in surgery at the Montreal General Hospital before returning to the United States in 1935 as an instructor in pathology and in 1936 as a resident in surgery at Howard University Medical School in Washington.

In 1938, Dr. Drew received a two-year Rockefeller Foundation fellowship at Columbia University which gave him an opportunity for advanced research in methods of preservation and banking of blood.



Charles R. Drew, M.D.

In 1940, he became the first black to receive the doctor of medical science degree. After returning briefly to Howard University, Dr. Drew was selected to organize shipments of blood to Britain in World War II and perfected methods of preparation of liquid and freeze-dried plasma. When the United States entered the war, Dr. Drew was named director of the American Red Cross Blood Program supplying blood and plasma to the Army and Navy, but resigned after three months when the Armed Forces informed the Red Cross of the official policy of refusing blood donations from nonwhites. Back in Washington as professor of surgery at Howard and chief of staff at Freedmen's Hospital, he devoted his full time to the training of black physicians and surgeons. Dr. Drew lost his life in an automobile crash in 1950 at the age of 46 while enroute to a medical meeting at Tuskeegee University.

Isidro Ayora, M.D., was born in Ecuador and received his medical degree from the Central University of Quito in 1905. Immediately after graduation he established a medical practice in Quito and also served on the faculty of medicine at Central University. Dr. Ayora became interested in gynecologic surgery and went to Berlin to study pathology under Virchow and gynecologic surgery under von Bumm and Olshausen.

Upon his return to Ecuador, Drs. Ayora and Villavicendio established the first clinic in Ecuador equipped to use modern diagnostic and treatment methods. In 1913, Dr. Ayora represented Ecuador at the 16th Latin American Medical Congress in Lima, Peru, where he presented a paper entitled "The Pelvis of Ecuadorian Women."

While serving as rector of Central University of Quito during the revolution of 1925, he was appointed provisional president of Ecuador in 1926 and then elected president, serving so until 1931.



Andrija Stampar, M.D.

Andrija Stampar, M.D., (1888–1958) was born in Drenovac, Yugoslavia, and received his medical degree from the University of Vienna, Austria, in 1911. He immediately embarked on a career in public health, which had been started while a medical student with a series of social health pamphlets. In 1913, Dr.



Ex-Presidente de la República 1879-1979

Isidro Ayora, M.D.

Stampar became district health officer and helped to control two cholera epidemics. During World War I, he served as an army surgeon in prisoner of war camps. After the war Dr. Stampar joined the Croatian Social Welfare Commission and in 1919 became chief of the Yugoslavian Health Services in Belgrade. In 1922, he founded the Institute of Social Medicine at Zagreb University, which, in 1958, became the Stampar School of Public Health. In 1946, Dr. Stampar was appointed president of the Economic and Social Council of the United Nations. In 1948, he was elected the first president of the World Health Organization. In 1955, WHO awarded Dr. Stampar the Leon Bernard Prize and Medal for achievements in social medicine.

LETTERS TO THE EDITOR

Serendipity

December 29, 1982

Dear Dr. Krosnick:

In 1939, I read a short article written by an author who claimed a cure for kraurosis vulvae and leukoplakia vulvae by using vitamin A ointment. Fortuitously within a period of three weeks, I examined six women in their late 30s and 40s, with severe leukoplakial lesions of the vulvae. I prescribed vitamin A ointment with excellent results in all six women. One of the women casually mentioned that since she had started the treatment, her breasts, which always had been painful, became completely pain free. A light flashed! Could it have been a systemic effect of vitamin A?

To answer this, I decided to use oral doses of vitamin A in those patients with painful breasts whether premenstrual or not. Since vitamin A in oil was not pleasant to take, I used an aqueous solution in doses of 10,000 to 20,000 units per day for periods of three months. I had an excellent result in 80 percent of the cases, good result in 15 percent, and no change in 5 percent. There was no evidence of vitamin A toxicity in any of these patients. A few relapses occurred after two to three months off the medication, but upon renewing vitamin A, the symptoms and signs cleared. Not only did pain disappear, but the characteristic tenderness and lumpiness faded away.

Upon resuming my practice after World War II, I continued this regime using Alphalin®, a water-soluble vitamin A capsule, in doses up to 50,000 units per day, with no signs of toxicity in over 3,000 individuals.

In 1966, I started to use vitamin A in cancer patients after mastectomy and gained the impression of increased survival rate and comfort. One postmastectomy patient in the early 1970s, who also was on chemotherapy, developed jaundice; the vitamin A was stopped and in a few days the icterus was improved greatly. This was the only time I noted an adverse reaction. Vitamin A was not started again and only chemotherapy was used. Now there are many reports in the literature concerning vitamin A and breast cancer, some of which are very convincing as to its efficacy in prevention and cure.

About 1950, there was a short letter published in *Medical News* from a surgeon working in the Mississippi leper colony. He reported a patient with leprosy who, on admission, had signs of an ovarian tumor. At operation, she had extensive ovarian carcinoma with metastases and ascites. Some tissue was resected and an unknown amount of x-ray was given. Prognosis was considered poor. However, this lady made a fine recovery and two years later appeared to be completely free of cancer.

Again the light went on! The only other medication she received was Dapsone®, a prescription used for treatment of her leprosy. From 1952 to 1954, I had seven cases of ovarian carcinoma proved by biopsy specimens at surgery. All were extensive with involvement of omentum and visceral structures. I removed as much tissue as possible and treated the patients with five doses of Cytoxan® daily postoperatively and once a week for two months. All were given deep x-ray therapy (ortho voltage). In addition, I put them on Avlosulfone® 100 mg daily which they continued to take at least two years and then stopped. All of these women lived normal lives from 15 up to 20 years and died from diseases not related to their ovarian cancer. They were followed at six-month and later one-year intervals with no evidence of recurrence.

Thinking that this medication perhaps was only effective in ovarian tumors, I did not again try it until I treated a man with severe lymphoma of the retroperitoneum with biliary and intestinal obstruction. Obstructions were relieved with bypass surgery; we administered 5,000 units of cobalt radiation and prescribed Avlosulfone® 100 mg O.D. He gained weight and continued in reasonably good health for ten years until he died from heart disease.

Most recently, I had two cases of cancer of the colon with extensive liver disease. Both patients had a colon resection, followed by 5-FU prescribed by medical oncologists. These patients were friends of my family; they were hardly able to get out of bed and had lost up to 40 pounds or more. In each case, the oncologist was approached about using Avlosulfone® and, though no approval was given, there were no strong objections. The families wished to try the medication. In two weeks after starting the Avlosulfone®, both patients were up and about; their appetites greatly increased and their weight went up to their normal. The woman went snow-mobiling within two months, but after eight months did not renew her prescription for four weeks and although she started again, she rapidly went downhill and died. The man put an additional room onto his house and a year later continues on chemotherapy. Since the liver metastases remained unchanged, a hepatic artery catheter was inserted and with that therapy his liver metastases decreased about one-third. He is continuing his Avlosulfone®, feels quite well, and has not lost weight.

One can wonder whether there might be a toxic reaction to this medication. I did repeated counts and chemistries on these people and found no evidence of toxicity. There was no nausea at doses up to 200 mg a day.

I do not claim that we have a cure for cancer. I do not know how Avlosulfone® works, but I think it has to do with the immune system. I do not know that animal experiments could help—further clinical work could.

I do know it has been used in leprosy for years with favorable results. I do know that within the past four to six months an article appeared in a journal comparing similarities between leprosy and cancer. I do know I have gone as far as I can go with this and I hope someone can pick up the ball and run with it.

(signed) Nicholas A. Bertha, M.D.

Quo Vadis 1984

January 4, 1983

Dear Dr. Krosnick:

Regular readers of *The Journal* should be familiar with my views regarding MSNJ, or at least where I am coming from. My positions can be summarized as striving to preserve the private practice of medicine and the doctor-patient relationship, and actively resisting intrusion of external force, particularly government into that sphere. How we

arrived at our present state must be understood before we can address the more pressing problem of where we are going.

In the years 1978, 1979, and 1980, I wrote extensive critiques of the annual meetings in an attempt to convey to those not present an awareness of what was and was not being accomplished to further their interests. Too often the stress was on actions not taken and policies not implemented. Over that period, I personally achieved success in passing a steadily increasing number of my resolutions. Inadequate implementation of previous resolutions, unjustified policy reversals, and postponement of decisions on vital issues offered plenty of material for comment. Constructive suggestions always were included.

By 1981, most of my dire predictions had been substantiated. As a result, all my resolutions that year were adopted. Fortunately, for other reasons, I neglected to submit my annual critique.

The year 1982 arrived with the realization once again that implementation of the policies established the previous year had been woefully minimal. Dr. Howard Slobodien, the incoming President, promised that he would try to do a better job. In my opinion, his efforts have been commendable. However, years of procrastination and indecision coupled with a virtual deluge of governmental intrusionary legislation have created a situation that will require years of extraordinary effort if we are to slow, stop, and reverse the present trends.

MSNJ is in desperate need of more members. Attracting new members, short of coercion, can only be accomplished by actively and effectively protecting the rights and interests of the membership. This alone can stimulate the flow of dues, as well as the active interest and participation of those we wish to attract.

There has been a growing usage of the term good old boys in reference to the Board of Trustees. While it offers their Chairlady, Dr. Palma Formica, a humorous opportunity to issue a disclaimer, it also signifies a less-than-confidence inspiring image. For too long the processes of election and appointment have resembled the version common to New Jersey lay politics. The major offices often are filled by a fait accompli through the Nominating Committee, since their recommendations traditionally are unopposed. Their decisions, in turn, frequently are arrived at by trade-offs of "owe me's" between county societies. When MSNJ primarily was a social and educational organization, it was reasonable to reward loyalty and effort with a token title. In the present life and death struggle, it would be suicidal to entrust leadership of the society to anyone on the basis of such outdated criteria.

The present system is fashioned around a three-year apprenticeship en route to the presidency. The final election involved is that for president-elect. To follow the customary procedure this year would involve running against one of the best qualified candidates yet offered for second vice-president. To wait until next year would postpone what I perceive as the needed leadership still further. In view of these facts, I have decided to run from the floor for the office of president-elect.

I firmly believe that this is the appropriate time, before time runs out, to change the passive ineffectual image of MSNJ. I feel that I have established my prophetic wisdom. I have proved that impossible odds can be beaten. I have acquired an extensive knowledge of the issues involved. And most of all, it is my impression that the doctors of New Jersey are ready to fight back, if given the means for such resistance.

I have vowed to confine my campaign to issues, rather than personalities, so let me apologize in advance for my slogan: Does this moribund society need a pathologist to preside over the autopsy, or an obstetrician to attend its new birth?

(signed) Frank J. Primich, M.D.

Explaining the Paradoxical Effect of Stimulants for Hyperactivity to Parents

December 6, 1982

Dear Dr. Krosnick:

Disregarding the group of hyperactive children who do not benefit from cerebral stimulants, the "paradoxical" effect of stimulants is not paradoxical at all.

Children benefiting from stimulants are suffering from relative functional cortical hypoarousal, allowing subcortical, extrapyramidal, more primitive centers to maintain or reassume their phylogenetic priority beyond the development, age appropriate state which results in deficient stimulus control on that level.

Cortical stimulants improve the dominance of cortical functions, achieving a "pharmacological pseudomaturation."

Confirmatory neurophysiologic evidence for this explanation is provided by the electroencephalogram. It has been our experience over the past 16 years that hyperactive children with slow electroencephalograms (EEGs) tend to benefit from cerebral stimulants whereas children with normal EEGs or dysrhythmic EEGs without accompanying slowing do not.

When explaining the medication effect to the parents, we simply point out that the biological animal in such children had not been tamed adequately because of inadequate maturation of higher brain centers which normally control movements and other functions deficient in the hyperactive child. We mention that the medication in part and for the time being will substitute for this lag in development or dysfunction variation until, hopefully, further brain maturation will take place. This plausible explanation usually is accepted readily.

(signed) Mary B. Lutz
Elmar G. Lutz, M.D.

Intrapulmonary Neurilemoma

December 15, 1982

Dear Editor:

I read the article, "Intrapulmonary Neurilemoma: A Rare Neurogenic Tumor," by G.T. Veliath et al. which appeared in *The Journal* (December, 1982), with some skepticism. The single photomicrograph does not illustrate the Antoni type A and type B areas described in the text and no mention is made of argyrophilic stains or ultrastructural studies. Before a diagnosis of neurilemoma of the lung is made strong consideration should be given to the diagnosis of spindle cell carcinoid tumor which may mimic a neurilemoma (*Am J Surg Pathol* 4:315, 1980; *Human Pathol* 10:601, 1979; *Arch Pathol* 89:374, 1970). The distinction is not an academic one because even without atypical features, 20 percent of these tumors metastasize.

(signed) Raymond Schiffman, M.D.

January 10, 1983

Dear Dr. Krosnick:

With reference to Dr. Schiffman's letter, all the appropriate studies were done to obtain a competent pathological diagnosis. The case also was reviewed by several pathologists. The microphotograph submitted with the article was a representative study and not intended for a spot diagnosis.

(signed) George T. Veliath, M.D.

Housing Application

217th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY
April 29-May 2, 1983

	Single	Twin	Daily Rates
Resorts International (headquarters hotel)	$75.50	$75.50	$161/$201
Caesar's Boardwalk Regency	$70.00	$70.00	Rates quoted upon request
Claridge Hotel	$65.00	$65.00	Rates quoted upon request

Rates subject to 12% state and local taxes

ALL hotel reservations for the 217th Annual Meeting, MSNJ, will be handled by the Atlantic City Convention Bureau. Please send your housing application directly to the Bureau, 16 Central Pier, Atlantic City, NJ 08401. Complete your 1st, 2nd, and 3rd choices of hotel. All Delegates and Members are urged to make their hotel reservations early. Blocks of rooms will be available at Resorts International (headquarters hotel), the Claridge Hotel and Casino, and Caesar's Boardwalk Regency. The reservations deadline at all three hotels is March 29, 1983. All registrants will be charged for three nights: Friday, Saturday, and Sunday, April 29, April 30, and May 1, 1983.

MAIL THIS APPLICATION DIRECTLY TO THE ATLANTIC CITY CONVENTION BUREAU
16 Central Pier
Atlantic City, NJ 08401

Please list 1st, 2nd, and 3rd choices; confirmation will come directly from hotel.

1st Choice _____ 2nd Choice _____

3rd Choice _____

Accommodations desired: ☐ Single ☐ Twin ☐ Suite Parlor & 1 Bedroom
☐ Suite Parlor & 2 Bedrooms

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Will arrive _____ (date) Time _____ Will depart _____ (date) Time _____

☐ Check if Official Delegate _____ County _____

UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY

UMDNJ—NEW JERSEY MEDICAL SCHOOL

NEUROLOGICAL SURGERY

"ANNUAL MANAGEMENT OF HEAD TRAUMA IN THE 80'S"

MARCH 19-20, 1983

Resorts International Hotel, Atlantic City, NJ

SYMPOSIUM FEATURING THE LATEST UPDATE ON THE MANAGEMENT OF HEAD TRAUMA

For information and reservation contact:
Mrs. Denyse Adler, (201) 456-4756

Abbott J. Kreiger, M.D.
Chief

Otakar R. Hubschmann, M.D.
Program Director

The Academy of Medicine of New Jersey
presents a symposium on

"COMA & SURVIVAL"

on
WEDNESDAY, APRIL 6, 1983
1:00 P.M.-5:00 P.M.
at
SAINT BARNABAS MEDICAL CENTER
Livingston, New Jersey

The program will include presentations by nationally prominent speakers on stupor and coma in the neonate, the infant, and the adult; traumatic coma, prognosis and latest techniques in treatment; pathophysiology, prognosis and treatment of coma; treatment and results in acute cerebral and spinal cord injury; latest therapy in coma and chronic spinal cord injury. This program is designed for general practitioners, internists, neurologists and neurosurgeons as well as allied professionals working in the field.

For further information contact:
Executive Office
Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
Phone: (609) 896-1717

LIKOFF CARDIOVASCULAR INSTITUTE
of Hahnemann Medical College & Hospital
230 N. Broad Street, Philadelphia, Pennsylvania 19102 (215) 448-8063

CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

WEDNESDAY, APRIL 6, 1983

20 minute lectures—Questions and Answers (10 minutes)
MODERATOR: BERNARD L. SEGAL, M.D.

SELECTION OF PATIENTS FOR CORONARY BYPASS SURGERY: 1983
Bernard L. Segal, M.D.

AMBULATORY ECG MONITORING: USES AND ABUSES—CASE PRESENTATION
Leonard N. Horowitz, M.D.

THE INTERPRETATION OF COMPLEX CARDIAC ARRHYTHMIAS—CASE PRESENTATION
Gary J. Anderson, M.D.

CASE PRESENTATION/DISCUSSION
Ronald S. Pennock, M.D.

STREPTOKINASE AND ACUTE MYOCARDIAL INFARCTION: 1983 UPDATE
Gary S. Mintz, M.D.

3:00 PM—2nd floor New College Building, Hahnemann University
• NO REGISTRATION FEE • NO ADVANCE REGISTRATION REQUIRED •
• CME CATEGORY I CREDITS CERTIFIED •
WINE & CHEESE SERVED FOLLOWING CONFERENCE

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, The Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

May

19 **Anesthesia for Neurosurgery**
4-5:30 p.m.—New Jersey Medical School, Newark
(UMDNJ and AMNJ)

CARDIOLOGY

April

13 **Indications for Invasive Cardiac Studies**
11:30 a.m.-12:30 p.m.—Rahway Hospital
(AMNJ)

22 **Ventricular Arrhythmias: To Treat or Not To Treat**
11:30 a.m.-12:30 p.m.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

May

14 **Radionuclide Evaluation of Cardiac Function**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

27 **Primary and Secondary Prevention of Coronary Artery Disease**
11:30 a.m.-12:30 p.m.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

MEDICINE

April

1 **Renal Conferences in Nephrology**
15 4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section of AMNJ)

2 **Gallstone Dissolution**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

2 **Intraocular Lenses and YAG Laser**
8 a.m.-2 p.m.—Eye Institute of New Jersey, Newark
(UMDNJ and Eye Institute of New Jersey)

5 **Immunology**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

6 **Thromboembolism and Thrombolytic Therapy**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

6 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

6 **Coma and Survival**
1-5 p.m.—Saint Barnabas Medical Center, Livingston
(AMNJ)

6 **Dinner Meeting**
6-9:30 p.m.—Holiday Inn, Newark Airport
(Endocrinology Section of AMNJ)

6 **Eye Manifestation of Systemic Disease**
27 **Principles of Dermatologic Therapy**
12:30-2:30 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

6 **Endocrine Conferences**
13 3:30-5 p.m.—Rotates between Newark
20 Beth Israel Medical Center, University
27 Hospital, United Hospitals, Newark, and VA Medical Ctr., East Orange
(Endocrinology Section of AMNJ)

6 **1983 Internal Medicine Review Course**
13 3-6 p.m.—Clara Maass Medical Center,
20 Belleville
27 *(Clara Maass Medical Center and AMNJ)*

6 **Infections in the Elderly**
27 **Respiratory Therapy in Lung Disease**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

7 **Leukocyte Abnormalities**
9 a.m.—Freehold Area Hospital
(AMNJ)

7 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section of AMNJ)

8 **Medical Grand Rounds**
11:30 a.m.—University Hospital, Newark
(Endocrinology Section of AMNJ)

8 **Current Clinical Concepts in Rheumatology/Immunology**
12:15-1:15 p.m.—J.F. Kennedy Memorial Hospital, Stratford Div.
(UMDNJ, J.F. Kennedy Memorial Hospital, and AMNJ)

8 **Management of Acute Renal Failure**
8:15-9:45 a.m.—Overlook Hospital, Summit
(Overlook Hospital, Columbia University College of Physicians and Surgeons, and AMNJ)

8 **A New Approach to the Diagnosis of Thyroid Nodules**
8-9 p.m.—Rancocas Valley Hospital, Willingboro
(Burlington County Medical Society and AMNJ)

Menstruation—The Physiology and Pathology of the Menstrual Flow and the Effects of Hygiene Products
8- 9 a.m.-5 p.m.—Resorts International, Atlantic City
9 9 a.m.-12 noon
(UMDNJ and AMNJ)

11 **Current Trends in the Diagnosis of Hepatitis**
8-9:30 p.m.—Wallkill Valley Hospital, Sussex
(Wallkill Valley General Hospital and AMNJ)

13 **Dermatologic Lesions in Internal Medical Diseases**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

13 **Vasculitis: Polyarteritis and Fever of Unknown Origin**
9:30-11:30 a.m.—Riverside Hospital, Boonton
(Riverside, St. Clare's, Dover General Hospitals and AMNJ)

13 **Update in Dermatology**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

13 **Management of Infection in the Immunodeficient Patient**
20 **Sarcoidosis and Other Forms of Interstitial Lung Disease**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

16 **Clinical Approach to Rehabilitation of Sports and Spinal Cord Injuries**
9 a.m.-5 p.m.—Lawrenceville School, Lawrenceville
(NJ Society of Physical Medicine and Rehabilitation, American Academy of Physical Medicine and Rehabilitation, St. Lawrence Rehabilitation Center, and AMNJ)

16 **New Concepts in the Pathogenesis of Emphysema**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

19 **Hypertension**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

19 **Drug-Induced Disturbances of Water, Electrolyte, and Acid Base Balance**
4-5 p.m.—Academic Health Science Center, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

The Academy of Medicine of New Jersey
The Medical Society of New Jersey
The N.J. State Department of Health

present a symposium on

"CURRENT TOPICS IN DRUG AND ALCOHOL ABUSE"

on
WEDNESDAY, APRIL 13, 1983
9:00 A.M.-1:00 P.M.
at
UMDNJ-RUTGERS MEDICAL SCHOOL
Auditorium
Piscataway, New Jersey

The program will include presentations by nationally prominent speakers on CDS prescribing practices, medical aspects of cocaine abuse, and the impact of alcoholism on general hospital practice. The program is designed for physicians and all other health care providers who have encountered or do encounter any of these problems in their professional work.

For further information, please contact:
Executive Office
Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
Phone: (609) 896-1717

The Academy of Medicine of New Jersey
—Orthopaedic Section
The New Jersey Orthopaedic Society
UMDNJ-N.J. Medical School—
Orthopaedic Division
St. Joseph's Hospital and Medical
Center—Orthopaedic Department

present the

EIGHTH ANNUAL
N.J. ORTHOPAEDIC SYMPOSIUM
on
Saturday, April 9, 1983, 8 a.m.-4 p.m.
at
UMDNJ-RUTGERS MEDICAL SCHOOL
Piscataway, New Jersey

The program will include presentations by nationally prominent speakers on patellofemoral disorders; the role of the medial approach to open reduction of the congenitally dislocated hip; congenital anomalies of the upper cervical spine; L-rod instrumentation of the spine—its place in 1983; determination of amputation level and early management of amputations for trauma; a critical appraisal of enders nails in hip fractures; preliminary experience with the new purified form of chymopapain and electrical stimulation in the treatment of idiopathic scoliosis; as well as abstract presentations by New Jersey orthopaedists.

For further information contact:
Linda Bartolo
Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
Phone: (609) 896-1717

EMERGENCY PSYCHO-PHARMACOLOGY

April 14-15, 1983

Resorts International Hotel-Casino, Atlantic City, NJ

Sponsored by the CONSORTIUM FOR EMERGENCY PSYCHO-PHARMACOLOGY

A CONFERENCE—To consider Emergency Psycho-Pharmacology in the context of emergency/crisis service in the community • To clarify the involvement of the medical profession in emergency/crisis service • To identify roles of crisis center staff as team members

Speakers: Nathan Kline, MD
William Anderson, MD
Leopold Bellak, MD

Panel Discussion: Response to participants' questions and comments dealing with practical applications and implications

Workshops: Will address implementations, techniques, problems, and provide a place for exchange of ideas and experiences

Lunch and Dinner provided

Contact: Eugene O'Neill, ACSW: Conference Coordinator
Consortium for Emergency Psycho-Pharmacology
Guidance Center of Camden County, Inc.
19 E. Ormond Ave.
Cherry Hill, NJ 08034
(609) 428-1300

19 **Nephrology Lectures**
7:30-8:30 p.m.—Ramada Inn, Clark
(Nephrology Society and AMNJ)

20 **Occurrence and Resurgence of Zoonosis**
9:30 a.m.-3 p.m.—Sheraton Hotel, East Brunswick
(NJ Public Health Assoc., NJ Veterinary Medical Society, NJ State Dept. of Health, MSNJ, and AMNJ)

20 **Fluid and Electrolyte Imbalance**
10:30-11:30 a.m.—South Bergen Hospital, Hasbrouck Heights
(AMNJ)

20 **Rutgers Dermatological Conferences**
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

20-21 **First Annual Garden State Sports Medicine Symposium**
8:30 a.m.—Ramada Inn Convention Center, East Brunswick
(The Institute for Medicine in Sports, Hamilton Hospital, and AMNJ)

21-22 **New Jersey Blood Bank Annual Meeting**
9 a.m.—Resorts International, Atlantic City
(UMDNJ, NJ Blood Bank Association, and AMNJ)

21 **Hypertension-Diabetes: A Clinical Dilemma in Management**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

23 **Geriatrics—Practical Office Management**
8:15 a.m.-4:15 p.m.—J.F.K. Professional Mall, Stratford
(UMDNJ and AMNJ)

28 **Immuologic Aspects of Infectious Diseases**
11 a.m.-12:30 p.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

28 **Dinner Meeting**
7 p.m.—Overlook Hospital
(NJ Gastroenterological Society and AMNJ)

30 **217th Annual Meeting**
Resorts International, Atlantic City
(MSNJ)

May

1-2 **217th Annual Meeting**
Resorts International, Atlantic City
(MSNJ)

3 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section of AMNJ)

4 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

4 **Dinner Meeting**
6-9:30 p.m.—Holiday Inn, Newark Airport
(Endocrinology Section of AMNJ)

4 **William P. Burpeau Annual Award-Dinner**
6:30 p.m.—The Manor, West Orange
(Urology Section, AMNJ)

4 **Pets and Their Diseases Transmitted from Animals to Man**

11 **Hearing Loss**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

4 **Infectious Disease**

11 **The Early Rehabilitation of the Stroke Patient**

18 **Angina**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

4 **Internal Medicine Review Course**

11 3-6 p.m.—Clara Maass Medical Center,

18 Belleville
(Clara Maass Medical Center and AMNJ)

4 **Endocrine Conferences**

11 3:30-5:30 p.m.—Rotates between

18 Newark Beth Israel Medical Center,

25 University Hospital, and United Hospital, Newark and VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

5 **Cystic Fibrosis**
9 a.m.—Freehold Area Hospital
(AMNJ)

5 **Rational Use of the Microbiology Laboratory**
12:30-2:30 p.m.—Rutgers Community Health, 57 U.S. Hwy. 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

6 **Medical Grand Rounds**
11:30 a.m.—University Hospital, Newark
(Endocrinology Section of AMNJ)

6 **Renal Conferences in Nephrology**
4-5 p.m.—University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section of AMNJ)

10 **Infectious Diseases**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

12 **Pruritic Rashes on One Unit**
2 p.m.—John E. Runnells Hospital of Union County, Berkeley Heights
(AMNJ)

13 **Current Clinical Concepts in Rheumatology/Immunology**
12:15-1:15 p.m.—J.F. Kennedy Memorial Hospital, Stratford
(UMDNJ, J.F. Kennedy Memorial Hospital, and AMNJ)

14 **Radionuclide Evaluation of Cardiac Function**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

17 **Endoscopic Papillotomy and Common Duct Stone Extraction**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

17 **Syndrome of Isolated Hypoaldosteronism**
4-5 p.m.-Academic Health Science Center, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

17 **Nephrology Lectures**
7:30-8:30 p.m.—Ramada Inn, Clark
(Nephrology Society and AMNJ)

18 **Newer Developments in the Treatment of Hypertension**
9:30-11:30 a.m.—Riverside Hospital, Boonton
(Riverside, St. Clare's, Dover General Hospitals and AMNJ)

18 **Rutgers Dermatological Conferences**
6-9 p.m.—Rutgers Community Health Plan, 57 U.S Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

24 **Hematologic Effects of Radiation Exposure**
6:30-10 p.m.—The Landmark, Woodridge
(NJ Blood Club and AMNJ)

25 **Current Concepts in the Management of Diabetes Mellitus**
8:30 a.m.-12 noon—Perth Amboy General Hospital
(NJ Affiliate, American Diabetes Association, Perth Amboy General Hospital, and AMNJ)

26 **Treatment of Vasculitis**
11 a.m.-12 noon—St. Joseph's Hospital, Paterson
(AMNJ)

NEUROLOGY/PSYCHIATRY

April

4 **An Uncommitted Lesbian**
8:15-10:30 p.m.—5 Fairfield St., Montclair
(Essex Psychiatric Seminar and AMNJ)

4 **Neuroscience Conferences**

11 11:30 a.m.-12:30 p.m.—Bergen Pines

18 County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

4 **Psychiatric Case Conferences**

11 7:30-11:30 a.m.—Trenton Psychiatric

18 Hospital

25 *(Trenton Psychiatric Hospital and AMNJ)*

6 **Encephalopathies: Organic Causes of Mental Dysfunction**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

6 **The Closet Alcoholic Presenting as a Psychiatric Patient**
3-4:30 p.m.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)

6 **Clinical Toxicity of Antidepressants**

27 **Family Therapy**
3-4 p.m.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

6 **Symposium on Developmental/Behavioral Disorders: Update 1983**

8 8 a.m.—Meadowlands Hilton, Secaucus

9 *(Hackensack Medical Center and AMNJ)*

7 **Alzheimer's Disease: An Update**

14 **New Concepts in Multiple Sclerosis**
12 noon-1 p.m.—Carrier Foundation, Belle Mead

6 **Child Psychiatry Case Conferences**

13 10 a.m.-12 noon—Trenton Psychiatric

20 Hospital

27 *(Trenton Psychiatric Hospital and AMNJ)*

8 **Psychiatric Lecture Series**

15 1:30-5 p.m.—Trenton Psychiatric

22 Hospital

29 *(Trenton Psychiatric Hospital and AMNJ)*

13 **Third Samuel B. Kutash Memorial Lecture**
Nuclear War: Psychological Aspects of



JEFFERSON
MEDICAL COLLEGE
of
THOMAS JEFFERSON UNIVERSITY

Update in Internal Medicine

April 20-22, 1983

A 3-day intensive symposium sponsored by the Department of Medicine, Jefferson Medical College, 1025 Walnut Street, Philadelphia, PA.

Willis C. Maddrey, M.D., Course Director

A registration fee of $325 includes course syllabus and reception-dinner at the Philadelphia Hershey Hotel.

For further information, call Office of CME (215-928-6992)

TREATING CHILDREN WITH:

Psychogenic Behavior Disorders
Psychogenic Learning Disabilities

Friday, April 29, 1983
Harrah's Marina Hotel and Casino
Atlantic City Ballroom
Cost: $60.00 (Lunch included)
Special Diet Menus Available
(Indicate with reservation)
Free Parking (Bring receipt for validation)
Room Reservations Available
(Contact Harrah's prior to 4/7/83)

- **Morning Session:**
  "The Antisocial Child"
  "The Antisocial Adolescent"
  Psychodynamics and Psychotherapeutic Approache
  Questions and Answers
- **Afternoon Session:**
  "Psychogenic Learning Disabilities"
  "Separation Anxiety Disorder"
  Psychodynamics and Psychotherapeutic Approach
  (includes video tape presentation)
  Questions and Answers
  Summation

Accreditation:

- This conference has been approved by th Academy of Medicine of N.J. for 6½ C.M.E. cred hours.

Center for Human Development, Carmel Roa
P.O. Box 808, Millville, N.J. 08332
609-825-6810

St. Lawrence Rehabilitation Center
and New Jersey Society of Physical Medicine and Rehabilitation
present:

REHABILITATION OF SPORTS & SPINAL CORD INJURIES: NEW CLINICAL APPROACHES

A close look at today's fastest growing challenges in physical medicine and rehabilitation by leaders in the field.

Saturday, April 16, 1983
Kirby Auditorium Lawrenceville School, Lawrenceville, NJ
8:15 a.m. to 5 p.m.

SPEAKERS INCLUDE:

Philip J. Marone, M.D., Orthopaedic Surgeon, Philadelphia Phillies — "Evaluation and Management of Selected Acute Sports Injuries".

John F. Ditunno, Jr., M.D., Chairman and Professor, Department of Rehabilitation Medicine, Thomas Jefferson University Hospital; Project Director, Spinal Cord Injury Center of Delaware Valley — "Emergency and Acute Rehabilitation of Spinal Cord Injuries".

Bernard Sandler, M.D., Medical Director, Robert Wood Johnson, Jr. Rehabilitation Institute at JFK Medical Center in Edison, NJ — "Fitness and Rehabilitation of the Injured Athlete".

LUNCHEON SPEAKER: **Joe Klecko,** Defensive Lineman, New York Jets.

Fee: $100

CME credits approved: 5.5 credit hours / Academy of Medicine of New Jersey.

Overnight accommodations, cocktail reception and bus trip to Atlantic City available. Register now. Enrollment limited.

For more information, contact:
William E. Ryan, M.D., Medical Director,
St. Lawrence Rehabilitation Center
P.O. Box 6367
Lawrenceville, NJ 08648
(609) 896-9500, ext. 232

Prevention
7:30 p.m.—South Orange Middle School, South Orange
(Mental Health Assn. of Essex County)

4 Geriatric Psychiatry
2-3 p.m.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

4 Conference on Emergency Psychopharmacology
8:30 a.m.—Resorts Hotel, Atlantic City
(Consortium for Emergency Psychopharmacology and AMNJ)

8 Principles of Child Psychotherapy
8:30-10:30 p.m.—Office of Dr. Deutsch, 301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

9 Drug Therapy of Depression
12 noon—St. Mary's Hospital, Orange
(AMNJ)

9 Second Annual Psychopharmacology
0 In-Practice Course
9 a.m.-4:30 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

0 Assessment of Suicidal Risk
12:30-2:30 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

6 Clinical Problems in Sexual Development
8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

9 Treating Children with Psychogenic Behavior Disorders and Psychogenic Learning Disorders
9 a.m.-5 p.m.—Harrah's Marina Hotel Casino, Atlantic City
(Cumberland County Guidance Center and AMNJ)

May

2 Mixed Homosexual Identity
8:15-10:30 p.m.—9 Marquette Rd., Montclair
(Essex Psychiatric Seminar and AMNJ)

2 Sensory Examination
9 Examination of the Reflexes
6 Behavioral Manifestations of Neurological Diseases in Children
23 Case Presentation
11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

2 Psychiatric Case Conference
9 7:30-11:30 a.m.—Trenton Psychiatric
16 Hospital
23 *(Trenton Psychiatric Hospital and*
30 *AMNJ)*

4 Multiple Sclerosis
9:30-11:30 a.m.—Riverside Hospital, Boonton
(Riverside, St. Clare's, Dover General Hospitals and AMNJ)

4 Closet Psychiatric Patient Presenting as an Alcoholic
3-4:30 p.m.—Fairs Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)

4 Child Psychiatry Case Conference
11 10 a.m.-12 noon—Trenton Psychiatric
18 Hospital

25 *(Trenton Psychiatric Hospital and AMNJ)*

5 Psychosurgery: An Update
12 Endocrinologic Update for Practicing Neuropsychiatrists
19 Working with Families of Suicidal Persons
26 Fifth Annual John B. Atkinson Memorial Lecture in Psychosomatic Medicine
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

6 Psychiatric Lecture Series
1:30-5 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

12 Topic to be announced
8 p.m.—Hackensack Medical Center, Hackensack
(NJ Psychoanalytic Society and AMNJ)

12 Rainer Maria Rilke, the Poet: A Psychological Study
8-11 p.m.—Saint Barnabas Medical Center, Livingston
(NJ Psychoanalytic Society and AMNJ)

16 Principles of Child Psychotherapy
8:30-10:30 p.m.—Office of Lawrence Deutsch, M.D., 301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

18 Sleep Disorders
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

24 Neurology
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

OBSTETRICS/GYNECOLOGY

May

19 Clinical Approaches to the Patient with Ovarian Cancer
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

PATHOLOGY

April

7 Cell Biology
14 4-6 p.m.—Institute for Medical Re-
28 search, Copewood St., Camden
(Institute for Medical Research and AMNJ)

May

5 Cell Biology
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

21 Annual Meeting
9 a.m.-2 p.m.—Rutgers Medical School, Piscataway
(NJ Society of Pathologists and AMNJ)

25 Transfusions
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

PEDIATRICS

April

13 Pediatric Nutrition: The State of the Art
9 a.m.-5 p.m.—Holiday Inn, Route 1, North Brunswick
(UMDNJ-Middlesex General Hospital and AMNJ)

18 Pediatric Lecture Series
12 noon-1 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)

20 Childhood Diabetes
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

27 Common Problems in Adolescent Medicine
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

May

13 Poisoning: A Practical Approach to the Unknown Ingestion
8:15-9:45 a.m.—Overlook Hospital, Summit
(Overlook Hospital, Columbia University College of Physicians and Surgeons, and AMNJ)

16 Pediatric Lecture Series
12 noon-1 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)

24 Controversies in Pediatric Infectious Diseases
8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

25 Neonatal Resuscitation and Stabilization Workshop
8 a.m.-4 p.m.—Children's Hospital, United Hospital Medical Center, Newark
(Children's Hospital, UMDNJ, and AMNJ)

RADIOLOGY

April

7 Columbia Affiliate Radiology Lecture Series
5:30-6:30 p.m.—Morristown Memorial Hospital
(Morristown Memorial Hospital, Overlook Hospital, and AMNJ)

21 Joint Meeting
7:15 p.m.—Saint Barnabas Medical Center, Livingston
(NJ Institute for Ultrasound in Medicine, Radiological Society of NJ, and Diagnostic Radiology Section of AMNJ)

21 Nuclear Magnetic Resonance Imaging
7:30-9:30 p.m.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine, Radiology Society of NJ, and AMNJ)

May

5 Interventional Radiology
5:30-6:30 p.m.—Overlook Hospital, Summit
(Morristown Memorial Hospital, Overlook Hospital, and AMNJ)

5 Visiting Professor Program
26 1:30-5 p.m.—Saint Barnabas Medical
Center, Livingston
(Saint Barnabas Medical Center and AMNJ)

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For further information; contact the American Heart Association, Maryland Affiliate, Inc., 415 N. Charles Street, P.O. Box 17025, Baltimore, Maryland 21203. (301/685-7074)

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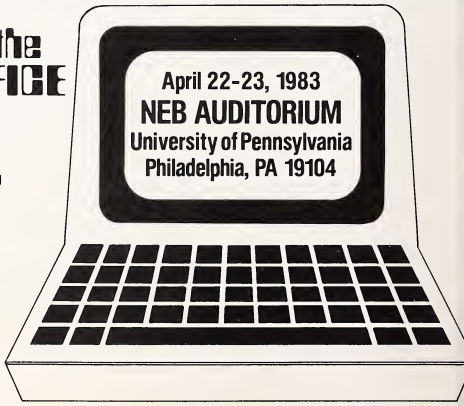
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8 **Update Arthritides**
5:30-6:30 p.m.—Overlook Hospital, Summit
(Overlook Hospital, Morristown Memorial Hospital, and AMNJ)

14 **Advanced Echocardiography**

15 8:30 a.m.—Nassau Inn, Princeton
(The National Foundation for Non-invasive Diagnostics and AMNJ)

18 **Topic to be announced**
6:30 p.m.—The Manor, W. Orange
(Radiotherapy Section of AMNJ)

SURGERY

May

27 **High-Risk Surgery**
12 noon-1 p.m.—Perth Amboy General Hospital
(AMNJ)

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastics, and Vascular Surgery)

April

2 **Intraocular Lenses and YAG Laser**
8 a.m.-2 p.m.—Eye Institute of New Jersey, Newark
(UMDNJ and Eye Institute of New Jersey)

9 **8th Annual Orthopaedic Symposium**
8:30 a.m.—UMDNJ-Rutgers Medical School, Piscataway
(AMNJ)

18- **Fifth Annual Vascular Symposium**
19 8 a.m.—Resorts International, Atlantic City
(UMDNJ and AMNJ)

26 **Sports Medicine in the Over-35 Professional**
8-10 p.m.—Englewood Club, 115 E. Palisade Ave., Englewood
(Englewood Surgical Society and AMNJ)

May

4 **Vascular Surgery**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

5 **Leukotomy (Lobotomy): An Update**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

MISCELLANEOUS

April

6 **Toxicology Seminars**

13 3 p.m.—Rutgers Medical School, Piscataway

20 *(UMDNJ)*

27

May

4 **Computers in Medicine**
11:30 a.m.-12:30 p.m.—Rahway Hospital
(AMNJ)

4 **Toxicology Seminars**

11 3 p.m.—Rutgers Medical School, Piscataway

(UMDNJ)

24 **A Historical View of Englewood Hospital**
8-10 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

OBITUARIES

Dr. Leonard M. Berry

Leonard Macy Berry, M.D., died on December 12, 1982. Born in 1909, Dr. Berry earned a medical degree from the University of Vermont School of Medicine in 1934. Dr. Berry was the co-founder of the Department of Physical Medicine and the Keepwell Baby Clinic at The Princeton Medical Center. Dr. Berry was a Mercer County deputy county physician. At the time of his death he was head of the industrial department at Zurbrugg Memorial Hospital, Riverside. Dr. Berry was a member of our Mercer County component and of the American Medical Association.

Dr. Leon C. Dwoyer

At the grand age of 83, Leon Charles Dwoyer, M.D., died on December 21, 1982. Dr. Dwoyer received his medical degree from Columbia University College of Physicians and Surgeons in 1932. He practiced in Linden for 37 years before retiring to Florida. Dr. Dwoyer was a retired member of our Union County component and a member of the American Medical Association.

Dr. James R. Herron

James Robert Herron, M.D., a member of our Camden County component, died on October 14, 1982. Born in 1915 in Camden, Dr. Herron earned a medical degree at Thomas Jefferson Medical College, Philadelphia, in 1940. Dr. Herron, an obstetrician and gynecologist, was affiliated with Our Lady of Lourdes Hospital, Camden. Dr. Herron was an Assistant Professor at Thomas Jefferson Medical College since 1950. Dr. Herron was a past president of the Camden County Medical Society, a Fellow of the American College of Surgeons, and a Diplomate of the American College of Obstetrics and Gynecology. During World War II, Dr. Herron headed the Army's 114th Medical Battalion, handling wounded troops for the Battle of the Bulge under General George Patton.

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Athletic Injuries to the Head, Neck, and Face

Joseph Torg, M.D. Philadelphia, PA, Lea and Febiger, 1982. Pp. 300. ($32.50)

Torg and his highly qualified contributors have prepared a comprehensive, well organized, factual, and timely text on the prevention, diagnosis, and treatment of some of the most dangerous, and even catastrophic, injuries to the head, neck, and face that occur in sports. The injuries discussed, in descending order of incidence, occur in football, water sports, trampolining, ice hockey, and racquetball.

Boxing injuries are discussed first; this is an imbalance since boxing does not have a proportionately high incidence of this type of injury. Baseball actually has a rather high incidence of these serious injuries, yet the discussion of them is minimal.

When these injuries are viewed by the television audience, they not only cause great suffering to the athlete, but provoke a public outcry for changes in rules and equipment to reduce the incidence. For example, because a West Point cadet was killed by a flying tackle, this maneuver no longer is permitted.

Athletic injuries never can be eliminated wholly by changes of rules and equipment; an injury-proof sport is one without adventure.

The book is divided into useful sections that deal with the various types of injuries. Anatomy, physiology, plain and special view radiographic evaluation, computerized tomography, and nuclear medicine are discussed and supplemented with excellent graphic material. (Some of the CT and radionuclide brain scan photographs might not be intelligible to the reader without special training, and perhaps this should have been omitted.)

The book was designed mainly for physicians and trainers, and yet the primary responsibility for prevention of massive injuries still lies with nonmedical people such as coaches. The advisors of athletes require substantial education to reduce major injuries to the head and neck areas. For example, a better use of hockey masks and goggles in racquet sports is indicated. Also, for example, defensive boxing is to be preferred to "head-hunting" or a head guard.

Physicians probably will be informed and impressed to learn about the important contribution of specialized athletic advisory organizations and persons such as coaches, exercise physiologists, bioengineers, and equipment manufacturers.

Many of the contributors to this book have made specific and vital modifications in equipment that undoubtedly will reduce the incidence and severity of injuries.

One of the best parts of the book is the instruction about moving an athlete with a potentially serious injury to the head and neck. A physician always should be the leader of any trainer or ambulance paramedic team in attendance.

The publication of this book, despite some minor flaws, represents a valuable addition to our knowledge about the management of athletic injuries.

Max M. Novich, M.D.

The Effects of Diabetes on the Eye: How Eye Problems Develop and How They Are Treated

National Society to Prevent Blindness, New York, NY, 1982. Pp. 47. ($4.00)

The National Society to Prevent Blindness has compiled a useful visual-aid manual for instruction of individuals in the treatment of eye complications of diabetes. The illustrations are excellent, depicting the anatomy of the eye; they are easy to explain and understand. Laser treatment is very well explained and illustrated but I believe vitrectomy can use fuller explanation. This booklet should be of considerable help to the clinician as he explains the treatment of eye complications to diabetic patients.

Samuel E. Einhorn, M.D.

The Newer Therapies: A Sourcebook

L.E. Abt, Ph.D., and I.R. Stuart, Ph.D., (eds). New York, NY, Van Nostrand Reinhold Co., Inc., 1982. Pp. 402. Illustrated. ($18.95)

The editors have assembled a set of contributions representing newer psychotherapies and innovative variations of standard treatment. As a sampler, this book is a worthwhile reading of current developments, as well as a guide to recent literature.

The creative methods advocated by the writers stimulate the imagination. Exposure to a wide range of ideas can enlarge the scope of awareness to include alternate ways of helping patients. These conceptual models and techniques need to be selected within a comprehensive framework of psychotherapy. Out of context, without diagnostic understanding, the unwary shopper in the cafeteria of different offerings could suffer indigestion from taking in too much that is tempting.

Only a few of the chapters discuss problems in the use of specific procedures. Diagnosis and suitability hardly are considered. Taking such limitations into account, the knowledgeable psychiatrist can derive some benefit from acquaintance with the work of the authors, discovering approaches which add appropriately to his skills as a therapist.

Leonard Hollander, M.D.

Pregnancy in Adolescence: Needs, Problems, and Management

Irving R. Stuart, Ph.D., and Carl F. Wells, Ph.D., (eds). New York, NY, Van Nostrand Reinhold Co., 1982. Pp. 441. ($26.50)

This book is an excellent compendium of original contributions on all aspects of adolescent pregnancy and parenthood. The editors ably met their objective to provide an overview of the current state of knowledge—the major problems and needs of this social/health issue with a refreshing focus on concrete and specific recommendations for management and program development.

The book is divided into four major areas: legal considerations, needs, problems, and management. The heaviest emphasis (10 out of a total of 19 chapters) is devoted to management, as is appropriate in a book written primarily for practitioners who work directly with adolescents who are pregnant and/or parents.

The first section on legal considerations provides an excellent and useful review of the current status of legal problems confronting practitioners who advise and treat teenagers. Information which is not easily accessible to physicians is included on such issues as: the rights of adolescents to terminate pregnancy with or without parental notification or consent; the liability of physicians for treating adolescents in the area of pregnancy-related care, venereal disease, drug and alcohol abuse, and contraception; termination of the teenage parent's rights; and the rights of the emancipated minor and the "mature minor."

The second section on needs consists of four chapters. In combination, they provide an overview of the epidemiology of teenage pregnancy, as well as a consideration of the various biological, personal, family, and social factors that the practitioners should consider in determining the range of health care and social services needed by the individual adolescent and her family.

The third section on problems also consists of four chapters, one focusing on medical and psychosocial risk factors, the other three on various aspects of adolescent contraceptive use or failure. This is the weakest section of the book with some repetition of areas covered in other parts of the book and an overemphasis on several of the authors' research projects. The section is saved, however, by a very interesting chapter describing the program developed at the Michael Reese Hospital and Medical Center, Chicago, called "The Young Adult and Adolescent Decision Making About Contraception (YADMAC) Program." YADMAC successfully emphasized increased use and continuance of contraceptives in low-income inner-city girls at high risk for adolescent pregnancy through a peer group program.

The final section on management consists of nine chapters and covers, with varying success, a range of issues and programs. Four chapters of particular interest include: a discussion of the variables affecting the adolescent's decision to deliver or to abort her pregnancy; another on interventions with families of pregnant adolescents; a chapter on helping young men make more effective (less macho, more mutual) decisions about sex, contraception, and pregnancy with a useful listing of educational materials on this frequently overlooked topic; and a detailed description on how to set up an innovative, school-based program for pregnant adolescents.

The one minor flaw in the book is that some authors repeat material on topics covered by other authors, particularly on the tasks of adolescence, the complications of adolescent pregnancy, and the factors influencing contraceptive failure. This flaw is counterbalanced in part by each author generally taking a slightly different perspective on the repeated topics.

I would recommend this book highly as an excellent and practical reference work for any practitioner interested in pregnant adolescents or teenage parents.

Diane K. Shrier, M.D.

Safe Delivery: Protecting Your Baby During High-Risk Pregnancy

Roger K. Freeman, M.D., and Susan C. Pescar. New York, NY, Facts on File, Inc., 1982. Pp. 314. Illustrated. ($14.95)

To write a book about the problems that can occur in pregnancy is difficult. To attempt to put those problems in language that a layperson can interpret almost is impossible. Such a text often is too superficial for the professional and too technical for the ordinary reader.

Safe Delivery attempts to discuss the medical and obstetrical problems that can complicate a pregnancy. Before-pregnancy evaluation is encouraged and every woman is advised to insure by a blood test that she is rubella immune before attempting pregnancy. Such a recommendation is not as clearly made for the women of Askenazi Jewish background to have a blood test for the transmittable trait of Tay-Sachs disease even though this test readily is available.

A more serious shortcoming must be mentioned. In discussing bleeding during the first three months of pregnancy the authors state that in the majority of cases the conceptus has a significant abnormality that would make survival impossible. The authors mean to say that in those pregnancies that go on to a miscarriage the conceptus often was found to be abnormal. Most obstetricians feel that bleeding in the 1st trimester is not a significant predictor of a fetal abnormality if the pregnancy continues to term.

The authors, in trying to anticipate and explain the different therapeutic modalities suggested by various physicians, often leave the reader unsure of what should be done. The difficult decision to deliver at a level III institution that may be located in a distant city is mentioned but no solution is offered.

This book may be recommended for the intelligent woman who desires to participate in her high-risk pregnancy by being well informed. In spite of a careful attempt to accurately simplify medical and obstetrical conditions and to explain diagnostic procedures such as amniocentesis, contraction stress tests, and fetal monitoring, the material presented may be too formidable for the average reader, even a highly motivated one.

Gerard F. Hansen, M.D.

Surgical Care of the Patient with Renal Failure

Nicholas L. Tilney, M.D., and M. Michael Lazarus, M.D. Philadelphia, PA, W.B. Saunders Company, 1982. Pp. 240. ($39.50)

Drs. Tilney and Lazarus have published a relatively small volume entitled, *Surgical Care of the Patient with Renal Failure*. It is divided into 12 chapters and includes such subjects as acute renal failure in surgical patients as well as ophthalmologic aspects of dialysis and transplantation. Some of the chapters appear to be more useful than others, and, in particular, I found the chapter on infection in dialysis and transplant patients to be very informative.

One of the main criticisms I have of this volume is that although it is published in 1982, in the first three chapters, only 19 of the 211 references cited were from the year 1980, and only one was from the year 1981, the remainder were all prior to 1979, some of them quite a bit before 1979. In the brief chapter on endocrine dysfunction and chronic renal failure, none of the references were as recent as 1980. Virtually all of the information is valid but I fail to see the need for this particular volume since all the information readily is available in the standard texts of nephrology.

From the point of view of the practicing nephrologist, I would recommend purchase of one of the latter volumes. I do not feel competent to make a recommendation to the surgeon who may in fact find it more useful than his non-operating colleagues. I particularly like one of the quotes in the second chapter on acute renal failure, "In terms of lives saved from acute renal failure, the helicopter in Viet Nam was a more useful machine than the dialyzer." This very pertinent observation is a humbling one for the practicing physician. Although there are many excellent qualities to this volume, I think the money could be better spent in other areas.

Robert Dodelson, M.D.

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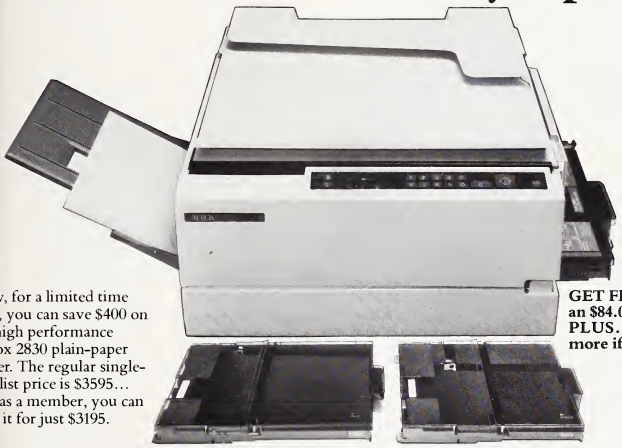
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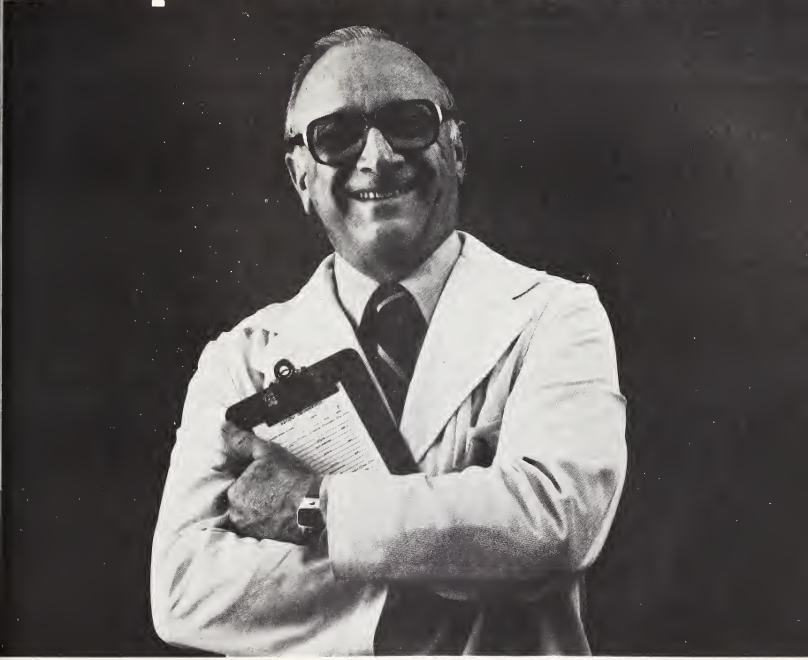
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On the Cover: The cover figure of the "Seated Woman Nursing Child" is a fine example of the remarkable art of the Colima (Western Mexico) culture (read the editorial on page 252). The article, "Maternal Deaths in New Jersey—1981" (page 261) describes some less happy results of pregnancy than that depicted by our cover photograph. "Seated Woman Nursing Child" is in the collection of Dr. and Mrs. Albert L. Rosenthal. The artwork was photographed by Ernestine W. Rubins.

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J-9043-4 July 1981

A Form For Consent

The primary purpose of a consent form is to record an informed consent discussion between the physician and the patient. Unfortunately, too often consent forms become lengthy and utilize technical jargon that is unintelligible to the average patient. This coupled with the problem of how explicit the form should be may result in patients signing a consent form without truly being informed.

Carol Janik, Joyce Swaney, Sandra Bond, and John Hayes, Research Assistants for Communications Design Center at Carnegie-Mellon University, decided to produce a consent form which did inform the patient. The researchers adhered to the five generally accepted items of information included in a consent form (what is to be done, why, by whom, risks, and alternative methods of treatment) throughout the project.

However, their main focus centered on three major areas: (1) meeting the needs of the people who use consent forms; (2) deciding how explicit to make the information in the form; and (3) designing the form so that it will be used correctly.

The researchers improved the readability of the consent form by eliminating unnecessary phrases such as "hereby" and "thereof," concentrating on the simplification of words, and avoiding repetitious phrases like "acknowledge" and "understand."

The researchers found it necessary to develop a separate form for surgical procedures rather than lump surgical and nonsurgical procedures in a single form.

The revised form, as shown in Figure 1, has been divided into four sections. The first part contains the five items generally included in a consent form. It should be noted that the statement regarding "no guarantees" was preceded by a positive statement. Part 2 deals with the possible need for additional surgery during the course of the primary surgery. Part 3 is concerned with disposition of tissue. The researchers realized that these sections frequently are not part of a consent form, but felt that these are areas that can arise and should be discussed prior to surgery. Part 4 provides the necessary space for signatures and dates. The researchers felt that devoting a section for signatures added emphasis to the importance of reading the form and encouraged a greater flow of information from the physician to the patient.

According to the researchers, their revision ensures that patients have received the necessary information to be able to make an intelligent decision about their treatment.

The results of this study were reported in *Information Design Journal* and entitled, "Informed Consent: Reality or Illusion?" Copies of the study may be obtained by writing to the authors at 660 Foxhurst Drive, Pittsburgh, PA 15238.

IMPAIRED PHYSICIAN'S ESTATE MUST PAY AWARD TO CEREBRAL PALSY CHILD

The parents of a cerebral palsy child with impaired movement of his right arm and leg have received a substantial settlement from the insurer of an impaired physician.

According to United Press International, a New Jersey plaintiff sued her now-deceased obstetrician, because he was too intoxicated to attend the birth of their son in 1971.

The plaintiff testifed that the physician failed to meet her at the hospital when she arrived for delivery and that when he did show up several hours later he was so drunk that hospital officials would not let him into the delivery room. Three more hours elapsed before the hospital summoned another physician.

The settlement, completed on December 21, 1982, with Employers of Wausau, calls for payment of $375,000 immediately, $25,000 annually, additional outlays when the child becomes 25, 30 and 35, and $300,000 every five years until he reaches 70. Total payouts could amount to as much as $5 million. The settlement was against the physician's estate.

Still pending is a negligence action against the hospital physician. In return for the recently concluded settlement on behalf of the late physician, the parents dropped other charges in their negligence action against him. *Medical Liability Monitor,* Vol. 7, No. 12, December 27, 1982.

DID YOU KNOW . . .

A recent New Jersey Appellate decision (Hudgins vs. Serrano, et al., A-4432-79-T3) in a wrongful death action predicated on alleged medical malpractice resulted in a reduction in the award of $1,150,000 to $750,000? The Court felt the original award "shocked the conscience" and was disproportionately so gross as to constitute a manifest of injustice."

The Norcal physician-owned California malpractice insurance company declared a $10 million dividend to be shared among its 4,600 policyholders?

The Medical Association of Georgia's physician-owned malpractice insurance company, MAG Mutual, has cut its rates in half for psychiatrists, placing them in a separate classification with the lowest rates of any specialty?

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D. and A. Ronald Rouse, who are, respectively, Director of the Department and Director of Special Projects.

Patient's Name _____

City Hospital _____
Consent to Surgery

Part 1
Planned Treatment
To be completed by the doctor in common terms, before the patient signs this form.

1. Dr. _____ has explained to me that:
   a. I have the following condition: _____
   b. My condition needs to be treated because: _____
2. I authorize Dr. _____
   To operate on me or to appoint someone else to operate on me.
   The operation to be performed on me is as follows: _____
3. The doctor has explained that:
   a. The following risks are involved in the operation:
   b. All surgery involves risk such as severe loss of blood, infection, and heart stoppage;
   c. The surgery will be done in a responsible manner by licensed personnel. No guarantee has been made that the surgery will improve my condition;
   d. My condition could be treated in the following other ways which are not being used on me at this time: _____

Part 2
Additional Surgery
To be completed by the patient.

My doctor has explained to me that sometimes during surgery it is discovered that additional or other surgery is needed. If I need additional or other surgery during my operation:
☐ I authorize the doctor to proceed.
☐ I do not authorize the doctor to proceed.

Part 3
Disposition of Tissues
To be completed by the patient.

I request that anything removed from me:
☐ be disposed of by the hospital as usual, or
☐ other: _____

Part 4
Signatures
To be completed only after Parts 1, 2, and 3 are filled in.

• I declare that I have personally explained the nature of the patient's condition, the need for treatment, the operation to be performed, and the risks and alternatives listed in Parts 1, 2, and 3:
☐ to the patient.
☐ to the patient's closest relative or guardian: _____

Name _____

Address _____

_____ Phone _____

I have given the patient or the person named above an opportunity to ask questions which I have answered as fully as possible.

Signature of Doctor _____

Signature of Witness _____

Date _____ Time _____ A.M./P.M.

• The doctor has explained all of the information in Parts 1, 2, and 3, to me and has answered my questions.
I understand that a copy of this completed form will be given to me after I sign it.

Signature of Patient _____

Signature of Witness _____

Date _____ Time _____ A.M./P.M.

• The patient is unable to consent for the following reason: _____

I therefore give consent on the patient's behalf.

Signature of Closest Relative or Legal Guardian _____

Relationship to Patient _____

Signature of Witness _____

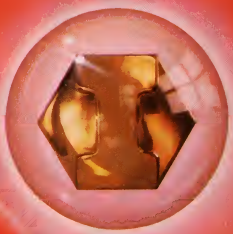
Date _____ Time _____ A.M./P.M.

Figure 1—Informed consent form.

A general practitioner in Washington, DC, recently lost an appeal over a $3,000 malpractice award to a patient? The doctor was not as concerned about the amount as he was about the reason for the judgment. He screamed at his patient. The court of appeals ruled that while screaming normally is not "extreme or outrageous conduct," this case was different. The patient had a fragile emotional condition the doctor knew about; screaming at her, therefore, constituted "intentional infliction of emotional distress." *Medical Economics,* December 20, 1982.

Increased malpractice claims have forced the Medical Defence Union, which insures 100,000 of Britain's physicians, to raise premiums by more than 44 percent to 195 pounds ($316) per year? Incidentally, British lawyers, through their British Law Society's plan, pay 1,361 pounds ($2,205) for liability coverage.

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INDERAL acts to reduce catecholamine-induced "spiking" of blood pressure which often coincides with the physical and emotional stress in a hypertensive's life[3] INDERAL reduces elevated heart rate, force of ventricular contraction, and cardiac work load—providing smooth control of hypertension to decrease the risk of related cardiovascular complications. (INDERAL should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.)

INDERAL works in a way that non-beta blockers can't—to provide long-term cardiovascular benefits.

INDERAL provides treatment for coexisting angina pectoris or cardiac arrhythmias in addition to reducing blood pressure—for comprehensive protection. What's more, INDERAL is well tolerated, acting with few of the distressing side effects of antihypertensive agents such as methyldopa or reserpine. Impotence, depression, sedation, orthostatic hypotension, and nasal stuffiness are rare. (Please see following page for Brief Summary of Prescribing Information, including side effects of INDERAL.)

Indeed, INDERAL has changed the face of antihypertensive therapy, worldwide. And it continues to do so—with an unparalleled record of clinical efficacy and experience.

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References: 1. Traub, Y. M., *et al.*: Clin. Pharmacol. Ther. *28*:765 (Dec.) 1980. 2. Hollifield, S.W., and Slaton, R.E.: Acta Med. Scand. *647* (Suppl.):67, 1981. 3. Cohen, J.D.: Propranolol vs. diuretics in initial therapy for hypertension. Medical Education Programs Ltd., Ayerst Laboratories, 1982.

INDERAL®
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Comprehensive Cardiovascular Protection

Please see following page for brief summary of prescribing information.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)
Inderal® (propranolol hydrochloride)

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG.

CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned, the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levarterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (*e.g.*, CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bro
chodilation produced by endogenous and exogenous catecholamine stimulation of bet
receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Because of its beta-
adrenergic blocking activity, propranolol may prevent the appearance of premonitory si
and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is espe
important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may b
accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY: The safe use of propranolol in human pregnancy has not been
established. Use of any drug in a pregnancy or women of childbearing potential requires
the possible risk to mother and/or fetus be weighed against the expected therapeutic b
fit. Embryotoxic effects have been seen in animal studies at doses about 10 times the m
mum recommended human dose

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely
observed if propranolol is administered. The added catecholamine-blocking action of t
drug may then produce an excessive reduction of the resting sympathetic nervous acti
Occasionally the pharmacologic activity of propranolol may produce hypotension and/
marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should b
observed at regular intervals. The drug should be used with caution in patients with imp
renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block, hypo
sion, paresthesia of hands, arterial insufficiency, usually of the Raynaud type; thromboc
nic purpura. *Central Nervous System:* lightheadedness; mental depression manifested
insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to
catatonia; visual disturbances; hallucinations; an acute reversible syndrome characteri
by disorientation for time and place, short term memory loss, emotional lability, slightly
clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointes:*
nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, me
teric arterial thrombosis, ischemic colitis. *Allergic:* pharyngitis and agranulocytosis,
erythematous rash, fever combined with aching and sore throat, laryngospasm and res
tory distress. *Respiratory:* bronchospasm. *Hematologic:* agranulocytosis, nonthrombo
cytopenic purpura, thrombocytopenic purpura. *Miscellaneous:* reversible alopecia. O
mucocutaneous reactions involving the skin, serous membranes and conjunctivae rep
for a beta blocker (practolol) have not been conclusively associated with propranolol.
Clinical Laboratory Test Findings. Elevated blood urea levels in patients with severe he
disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

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"INDERAL 20," contains **20 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-
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—Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinte
"INDERAL 40," contains **40 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-
81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-
—Each hexagonal-shaped, pink, scored tablet is embossed with an "I" and imprinted
"INDERAL 60," contains **60 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-
81) and 1,000 (NDC 0046-0426-91). Also in unit dose package of 100 (NDC 0046-0426-
—Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinte
"INDERAL 80," contains **80 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-
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Store at room temperature (approximately 25° C)

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Store at room temperature (approximately 25° C).

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Autopsy: To Do or Not To Do?

Hansen and Gregory, in this issue of *The Journal* (page 61), analyzed and discussed the implications of maternal deaths in New Jersey in 1981. Postmortem examination was not performed in 7 of the 18 patients that they studied. Among other things, the authors recommended that autopsies be performed on all maternal deaths, a view espoused by the Board of Trustees of the Medical Society of New Jersey.

The autopsy rate in the United States has been falling since World War II, even more drastically in the last two decades, declining to a national average of 21.7 percent in 1975. Reasons for the decline in autopsy rates are related directly to declining interests by physicians and surgeons, pathologists, families of the deceased, and hospital administrators.

The enormous recent advances in the clinical sciences, radiology, and laboratory medicine have resulted in overconfidence concerning clinical diagnosis in general; many physicians believe that little or no additional information can be obtained from autopsy, a notion that repeatedly has been proved erroneous. The fear that the autopsy will reveal a diagnostic or therapeutic error, a desire not to upset bereaved families, a possibility that malpractice litigation may ensue from autopsy findings, the lack of interest in witnessing autopsies, or the conferences that ensue from them are other factors that discourage physicians from requesting autopsies.

As presently practiced, autopsy pathology has many shortcomings that contribute in no small way to the declining interest in this discipline. There usually is a delay of several weeks, sometimes months, before the final autopsy diagnoses are reported—an experience usually exasperating for clinicians and for families of the deceased. Serious problems of communication between clinicians and pathologists exist as exemplified by autopsy reports that, in most instances, contain excessive verbiage in which inconsequential data and pathology jargon abound. Furthermore, pathologists tend to devote greater interest to other aspects of pathology such as surgical pathology, clinical pathology, and research. Hence, in most departments of pathology, the priority for autopsy pathology usually is low and the role is relegated to the most junior of residents and attending staff.

Traditionally, obtaining permission for autopsies from the families of the deceased always has been an uneasy, sometimes distasteful, task. Additionally, however, morticians tend to discourage families from giving permission for autopsies. The thought of autopsies in the minds of people sometimes conjures ideas of mutilation of the body. Refusal for autopsies occasionally is based on religious beliefs and the feeling that the patient in question has "suffered" enough. The elimination of a minimal autopsy rate requirement for hospital accreditation as well as the low yield-cost ratio associated with autopsies in these days of cost-containment also have contributed to the declining interests in autopsies.

And yet the benefits of autopsies to society and individuals cannot be overemphasized. Autopsies contribute immensely to the education of medical students, interns and residents, physicians, and other medical professionals; also, they serve a central role in "quality control" of medical care and provide data on new and old diseases and the changing pattern of these diseases. Further, autopsies clarify problems concerning medicolegal deaths and also provide organs and tissues for transplant.

Therefore, several methods have been suggested to revive interest in or upgrade the standards of autopsies. Among these are: improvement of communication between pathologists and clinicians for which concise, problem-oriented postmortem examination reports have been recommended, partial autopsies concerned with the major clinical problems and the elimination of the concept that all autopsies must be "complete," granting of adequate financial support for the autopsy service in hospitals, and the structuring of autopsies in such a way as to allow primary care physicians to receive continuing medical education credit for attending and participating in autopsies on their patients. In order to be able to provide a more satisfactory service, pathologists with special interest in autopsy (medical pathology) as distinct from surgical or clinical pathology need to be trained; at the same time, equal importance should be accorded autopsy pathology as for other areas of the specialty. Dynamism and interest could be infused into autopsies by the adoption of the "immediate autopsy" program that would make possible special studies such as ultrastructure and biochemical studies. An autopsy rate of 100 percent not only is ideal and desirable, but is a goal that can be attained.

A. Olusegun Fayemi, M.D.

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Approach to CNS Disease in AIDS—Attention Neurologists, Neurosurgeons, and Primary Physicians

Acquired Immunodeficiency Syndrome (AIDS) now is spreading at an alarming rate to involve not only homosexual men, Haitians, hemophiliacs (who receive factor 8), heroin addicts, but also children of drug addicts. We are witnessing an unprecedented number of central nervous system (CNS) lesions never seen before in man. Neurologists and neurosurgeons are not familiar completely with the CNS manifestations of AIDS.

AIDS in the central nervous system can present as an encephalitis due to cytomegalovirus, J.C. virus, toxoplasmosis, or herpes simplex. These lesions may be focal or generalized with little cellular response in the CSF and even present with a negative CT scan. On the other hand, meningitis due to cryptococcus neoformans, mixed bacteria, aspergillus, tuberculosis (typical and atypical), and even candida species have been described. Furthermore, solitary lesions due to brain abscesses, toxoplasmosis, progressive multifocal leukoencephalitis (PML), and tuberculosis have been noted. Plaque lesions due to white matter degeneration due to PML are increasing in number. There is one case of meningitis due to salmonella and nocardia species.

To further complicate the issue, noninfectious problems including psychiatric disturbances, peripheral neuropathies, vascular lesions, various types of seizures, lymphoma, and Alzheimer's disease are common manifestations of AIDS victims. The psychiatric manifestations are delusions, apathy, schizophrenia, hallucinations, and a prominent vacant stare. Painful paresthesia as seen in rabies, severe causalgia, progressive radicalopathy, and Guillain-Barré syndrome of AIDS mimics so many other conditions. Generalized seizures with or without inappropriate ADH (antidiuretic hormone) are therapeutic perplexing problems. Cerebral infarcts and epidural hematomas are rare vascular complications.

Although lymphoma of the brain has been described in AIDS, Kaposi of the brain remains limited thus far to extracranial sites. A syndrome similar to Alzheimer's disease has been seen.

There are two points to be made. Any patient presenting with neurological disease must be identified quickly as to whether he is part of one of the five recognized risk factor groups. This is done by asking specific lifestyle intimate questions no matter how embarrassing this might be. Secondly, after a CT scan, a rapid open brain biopsy with proper processing of the tissue, cultures, and proper stains is essential to diagnosing brain lesions. Spinal taps are done rapidly when no mass lesions are seen on CT scan screening for cryptococcal antigens and tuberculosis.

In essence, an aggressive neurosurgical approach is a absolute necessity in suspected cases. Serologies of these entities are extremely limited. Hence, please increase your index of suspicion and search for a tissue diagnosis; toxoplasmosis, tuberculosis, various bacterial, and fungal infections are treatable if observed early. Needless to say, however, such treatment only prolongs the fatal outcome from more malignant process. In the meantime, T-cell modifiers, hepatitis B vaccine, and interferon treatment are under study.

Leon G. Smith, M.D.

Seated Woman Nursing Child

The cover figure of "Seated Woman Nursing Child" is a fine example of the remarkable art of the Colima (Western Mexico) culture of the 4th to 10th centuries A.D. that consisted mainly of freehand modeling of small and large hollow clay figures and effigy vessels. Colima especially was noted for realistic representations of handsome people: "The female figures seem to demonstrate the Nahau preference for plump hips and a feminine concern with hairdressing."[1]

Statues and vessels were made in the shape of anything that interested the Colima artist: "Characteristic of the pottery of the Classic period of Colima are these playful and plastically interesting representations of common animals, particularly the hairless dogs that served as food and also were rendered in the shape of jugs and pots. The culture of Colima, as distinct from that of Nayarit and Jalisco, has fewer pre-Classic characteristics. Sculptures are of terra cotta, in shades running from cream to brown, and occasionally are painted a reddish brown to red. Subject matter is surprisingly varied, and both human and animal forms are habitually treated with realism. Common animals and men and women, shown in a variety of everyday activities, are depicted with affection and often with happy and even joyous expression."[1]

The article on maternal deaths in New Jersey (page 26) describes some less happy results of pregnancy than that depicted in our cover photograph.

A.K.

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

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Efficacy objectively demonstrated in the sleep laboratory—the most valid environment for measuring hypnotic efficacy.
In numerous sleep laboratory investigations patients fell asleep sooner, slept longer and woke up less during the night[3-12] with

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Dalmane®

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More total sleep time on nights 12 to 14 of therapy[4] and continued efficacy for up to 28 nights[5] with

Dalmane®

Rebound insomnia is avoided upon discontinuation [3,4,7] of

Dalmane®

Low incidence of morning "hangover"[14] with

Dalmane®

The efficacy of Dalmane has been studied in over 200 clinical trials with more than 10,000 patients.[3-15] During long-term therapy, which is rarely required, periodic blood, kidney and liver function tests should be performed. Contraindicated in patients who are pregnant or hypersensitive to flurazepam.

Please see summary of product information on following page.

erences: 1. Wil-
s RL, Karacan I:
duction, chap. 1,
leep Disorders:
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s RL, Karacan I,
ier SH. New York,
Wiley & Sons,
3, p. 2. 2. Data on
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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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The Medical Director

The traditional hospital medical staff leadership in the modern era has been the elected president, vice-president, secretary, treasurer, and medical director (or so-called chief of staff). In point of fact, all of these positions are held by physicians who are on the hospital attending staff in the active practice of medicine or surgery or their specialties. Those of us who have tried to juggle the exigencies of a busy practice and the sometimes onerous pressures of high staff office and its responsibilities on a daily, unrelenting basis sometimes have questioned the system. The older days were simpler—fewer doctors, smaller hospitals, simpler regimens of diagnosis and treatment, little or no concern about informed consent, and nary a thought about a potential law suit or charge of medical negligence.

Time, consumer protection legislation, and a consummate concern about perfection in medical practice with little room for any result less than a quintessent paragon, a pressure-cooker State Board of Medical Examiners and some plaintiff's attorneys, who appear more avaricious than righteous in their legal expeditions, have changed all of that. Licensure, certification, and recertification by specialty boards, continuing medical education credits, physicians recognition awards, general participation in hospital politics, committee activities, and self-governance have been heaped upon the already existent awesome responsibilities of the busy practitioner.

The president of the staff functions as the titular head of the medical staff and exerts the leadership role primarily as the chairman of the executive committee which in fact governs the medical staff from within. The president presides at general meetings, serves as ex-officio member of all medical staff committees (except the nominating committee), and is responsible for the enforcement of the medical staff constitution, bylaws, and rules and regulations and for compliance therewith. He implements sanctions when indicated and presents "the views, policies, needs, and grievances of the medical staff before the governing body and to the chief executive officer." The president "receives and interprets the policies of the governing body for the medical staff and reports to the governing body on the performance and maintenance of quality with respect to the medical staffs delegated responsibility to provide medical care." The president may be responsible for the educational activities of the medical staff and also may be the spokesperson for the medical staff in its external professional and public relations.

The traditional role of the medical director in previous years largely has been ceremonial except for a vague reference to "supervision of the clinical work in all departments," an assignment that is patently impossible for a volunteer. Until the past decade, the chief of staff had the significance of a supernumerary digit in his relationship to the business of board-CEO-medical staff functions.

The new medical director concept has been conceived out of necessity and only now is struggling for recognition as it pushes through the birth canal into a potentially hostile world of the medical staff. What is the medical director of the now and of the future? The medical director should be a full-time, salaried chief of staff, who has been a capable practitioner but who will set aside active clinical skills and patient practice to take up the formidable managerial and organizational skills that are required to take charge of all medical staff affairs. The medical director is hired by the CEO with approval of the governing body. The medical director is paid by the hospital and is accountable directly to the chief executive officer and to the governing body. Despite this, however, the medical director is not a "company man," but is the steward or chief executive officer of the medical staff.

The medical director has grave responsibilities and must have clearly defined authority to carry out the duties of the office—specifically to manage "the planning, organizing, direction, and control" of the high-quality medical care to the patients of the hospital by the members of the medical staff. The fraternal popularity contest of the past that selected a leader for one or more two-year terms is obsolete because the candidates for such office generally do not have the time or the skills to carry out the functions of the position.

THE SEARCH COMMITTEE

The selection of a medical director is a delicate and difficult task that should be assigned to a select group of hospital staff physicians, hospital trustees, and representatives of administrators who will serve as a search committee. The committee will seek applicants from within and outside the staff, review their credentials, and interview them. Obviously, the medical staff must be made fully aware of the position, its job description, and the new relationship of the medical director to the medical colleagues. Once the search committee has selected a candidate after leaving no stone unturned in the information-opinion gathering process, the name should be recommended to the governing board for approval and to the CEO for the actual appointment.

*The material for this column is coedited by Arthur Krosnick, M.D., Editor, *The Journal*, MSNJ; Vincent A. Maressa, Executive Director, MSNJ; and James E. George, M.D., J.D., Director of the Department of Professional Liability, MSNJ.

DUTIES OF THE MEDICAL DIRECTOR

The specific duties of the medical director include the following:

- Direct quality assurance committee.
- Meet regularly and as often as necessary with each department chairman to assure the high level of quality of care, discipline within each department and participation of its members in educational activities.
- Attempt to resolve disciplinary problems at the department level.
- Responsible to see that continuing medical education activities are of high quality and pertinent to the needs of the hospital in conjunction with the department chairmen.
- Monitor the attendance of all physicians at staff meetings, committee meetings, and educational activities, and see that each physician is performing those assignments for which he or she is responsible.
- Pay special attention to the quality, timeliness, and completion of medical records through the committee assigned to that task, and shall initiate discipline to members who fail to meet medical records requirements.
- Seek innovative though practical educational experiences and seek special funds where needed to accomplish this for the CME needs of the staff.
- Serve as the primary liaison physician between the medical staff, the administration, and the governing board.
- Assume the responsibility for creative planning for new professional services to enhance the overall quality of care within the institution.
- Participate in physician recruitment to fill special needs of the institution in terms of professional skills, geographical location, or other specific needs.
- Assure the board of directors of the credentials of applicants in conjunction with the staff credentials committee.

AUTHORITY

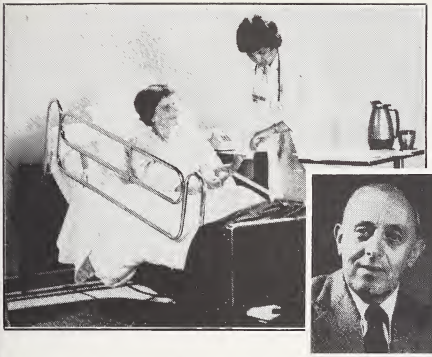
The position of the medical director must be recognized and respected by all staff physicians by virtue of its authority. The power, in the final analysis, shall be clearly defined and shall emanate from the Board of Directors through the chief executive officer. This final pathway may lead to extreme disciplinary action including suspension of staff privileges for causes.

QUALIFICATIONS

The candidate for medical director should be a seasoned, skilled, and respected clinician with ample experience in the administration of medical affairs. Prior services as an officer, executive committee member or member of other key committees, or a department chairman enhance the candidate's desirability. The candidate must be trustworthy, dynamic, diplomatic, yet firm and capable of interpersonal negotiations with consummate skill. This is not a job for a retiree.

SUMMARY

The medical director of a modern hospital staff must have a remarkable combination of skill, knowledge, charm, strength, and energy. The medical director must be prepared to deal with unpleasant situations and must recognize his inability to please all his medical colleagues on all occasions.



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BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions); in patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker, in one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levarterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (*e.g.*, CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure

USE IN PREGNANCY. The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function

ADVERSE REACTIONS

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands, arterial insufficiency usually of the Raynaud type, thrombocytopenic purpura. *Central Nervous System* lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory* bronchospasm. *Hematologic* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous* reversible alopecia. Ocular mucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

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—Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains **40 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99)
—Each hexagonal-shaped, pink, scored tablet is embossed with an "I" and imprinted with "INDERAL 60," contains **60 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0425-81) and 1,000 (NDC 0046-0425-91). Also in unit dose package of 100 (NDC 0046-0425-99)
—Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains **80 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99)
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Maternal Deaths in New Jersey—1981

ERARD F. HANSEN, M.D., Hackensack*
IARGARET GREGORY, M.D., Trenton*

ighteen maternal deaths were reported to and investigated by the ubcommittee on Maternal Mortality. The tetrad of anesthesia, sepsis, clampsia, and hemorrhage comprised all eight cases that potentially ere preventable. Suggestions are offered to prevent such tragedies in he future.

The Maternal and Child Health Program of the State Department of Health cooperates with the Committee on Maternal and Infant Welfare of the Medical ociety of New Jersey in a yearly study of all maternal deaths the state. Records are requested by the Department of ealth from any hospital or other facility experiencing a aternal death. Such records then are reviewed by an bstetrician member of the Subcommittee on Maternal lortality of the Medical Society of New Jersey. A summary prepared for presentation by the member at the annual eeting of the Subcommittee. This Subcommittee, consisting f practicing obstetricians and other physicians affiliated ith the Department of Health, assigns responsibility and egree of preventability after the facts, as known, are resented. Such a review enables educational efforts to be irected towards areas of care where improvement may be ought.

The mutual respect and cooperation between the State epartment of Health and the Medical Society of New ersey in self-monitoring efforts to improve maternal care is nother example of public and private sectors of health care orking together toward a common goal of decreasing aternal mortality.

ESULTS

There were 92,950 live births in New Jersey hospitals in 981; 18 maternal deaths were reported and presented to the Subcommittee for study.[1] Table 1 gives the classification and mortality rates as defined by the American College of Obstetricians and Gynecologists.[2] Other statistical data are summarized in Tables 2 through 5. Seven of the 18 maternal deaths did not have a postmortem examination.

Abdominal delivery, maternal age greater than 34, parity over 3, and being nonwhite are factors that seem to increase the risk of maternal death. Prenatal care was adequate in 60 percent of the cases. There were no deaths reported in patients under the age of 20.

A nonmaternal death is the death of a woman from causes not related to pregnancy or its management. Two of the three nonmaternal deaths were the results of car accidents. The third fatality was due to drug overdose postpartum. This is a vivid reminder that vehicular accidents are a major cause of death in young people. Pregnant women especially should be encouraged to use proper seatbelts to protect them and their unborn child from injury. Patients with a substance abuse problem may be treated more successfully during pregnancy when motivation is higher. Followup and adequate referral may prevent such needless loss of life.

An indirect maternal death is an obstetrical death resulting from previously existing disease or a disease that develops

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TABLE 1

Classification and Mortality Rates

Live births in 1981		92,950
Maternal deaths reported		18
Nonmaternal	3	
Indirect	4	
Direct	11	
Rate (indirect only)	4.3/100,000 live births	
Rate (direct only)	11.8/100,000 live births	
Rate (all causes)	19/100,000 live births	

TABLE 2

Characteristics of Maternal Deaths by Race, Age, and Prenatal Care

	Number	Percent
Race		
White	8	44
Other	10	56
Age		
Less than 20	0	0
20 to 34	13	72
35 to 39	4	22
Greater than 40	1	6
Prenatal Care		
Unknown	3	17
Adequate	11	61
Inadequate	2	11
None	2	11

Note: Maternal death rates by race and age could not be calculated since information on births by race and age in 1981 is not yet available.

TABLE 3

Parity and Duration of Pregnancy

Parity	Number	Percent
0	3	16
1 to 3	10	56
4 to 6	5	28
Gestational Age		
Less than 20 weeks	2	9
20 to 28 weeks	0	0
29 weeks through puerperium	16	91

TABLE 4

Classification and Preventability

Nonmaternal			3
Maternal			15
Indirect		4	
Nonpreventable	3		
Preventable	1		
Direct		11	
Nonpreventable	4		
Preventable	7		
Physician factor		7	
Patient factor		2*	

*In two deaths physician and patient shared preventability.

TABLE 5

Causes of Death

I. Nonmaternal	
Auto accidents	2
Drug overdose	1
II. Maternal	
A. Indirect	4
1. Nonpreventable	3
Cerebrovascular hemorrhage	1
Hepatitis	1
Uremia	1
2. Preventable	1
Pneumonia	1
B. Direct	11
1. Nonpreventable	4
Amniotic fluid embolism	2
Pulmonary embolism	1
Hemorrhage—abruption	1
2. Preventable	7
Anesthesia	2
Sepsis with DIC	1
Eclampsia	1
CVA secondary to preeclampsia coagulopathy	1
Hemorrhage	2
Placenta previa	1
Postpartum hematoma	1

during pregnancy, labor, or the puerperium which is not directly due to obstetrical causes, but is aggravated by the physiological effects of pregnancy. There were four such deaths, three of which were judged to be nonpreventable.

The potentially preventable death was due to pneumonia in a 20-year-old woman at 28 weeks gestation. The patient sought care late but it was felt that the seriousness of the problem was not appreciated on admission when more aggressive antibiotic therapy might have saved the patient. The fact that the patient came to the hospital late in the course of her illness places some responsibility on her and the medical system that places barriers, real or imagined, on the prompt seeking of medical care.

The three indirect nonpreventable deaths were due to one case each of cerebrovascular accident, hepatitis, and uremia secondary to end-stage renal disease. In each instance the care provided was up to the standards of the community.

A direct maternal death is an obstetrical death usually from complications of the pregnancy, labor, or puerperium, and from intercessions, omissions, incorrect treatment, or a chain of events resulting from any of these complications.

Two cases of amniotic fluid embolism and one case each of pulmonary embolus and hemorrhage due to an abrupti placentae were judged to be nonpreventable by present-da standards of care. In the latter case, the abruption occurre so quickly that even with heroic measures, the patie expired.

The seven direct maternal deaths that were felt to b potentially preventable comprised the tetrad of anesthesi hemorrhage, toxemia, and sepsis.

The first anesthesia death occurred when an endotrache tube had to be replaced during a cesarean section when th blood was noted to be unoxygenated. Failure to preo ygenate the patient adequately and insure proper placemer of the endotracheal tube were contributing factors. Th increased maternal vascular volume, increased oxygen d mand, and decreased residual volume, all call for meticulou care from an anesthesiologist trained in obstetric anesthesia.

The second anesthetic death was caused by sudde vascular collapse following an epidural anesthetic with 0.7 percent bupivacaine (Marcaine®). The possible causes of th reaction were: an inadvertent intravascular injection; a inadvertent subdural injection; an increased susceptibili

d sensitivity to the agent (an idiosyncratic reaction); and a nbination of the above.[3] As this reaction is rare, ob- trical anesthesiologists should be aware of this problem d be prepared to initiate resuscitative measures.[4] The true idence of this reaction is not known and perhaps "preven- ble hypoxia" may not be the case. The true etiologic agent y be inadvertent intravascular injection of a drug that has idiosyncratic reaction. Anesthesiologists are encouraged report such cases, treatments, and outcomes.

A death due to sepsis was due to failure to promptly iver and to examine frequently a patient with ruptured mbranes at term. Failure to adequately appreciate and lace blood loss was a contributing factor. Likewise the use furosemide (Lasix®) to combat decreased urinary output en the vascular status of the patient was unclear, was an or. Studies have shown that furosemide does not protect ainst renal failure by altering or increasing renal blood w but may cause renal failure by producing hypovolemia.[5] One patient suffered eclamptic seizures at home. She ired on admission to the hospital in spite of appropriate e. Review of the available antepartum records showed the od pressure to be elevated suggesting that the convulsion uld have been prevented by adequate treatment. The ord was incomplete so the Subcommittee was unable to ermine if treatment had been initiated to treat the pre- ampsia.

Two cases of death due to hemorrhage were investigated. e patient was admitted at 28 weeks gestation with a tory of heavy vaginal bleeding. She was a grand multipara d had received no prenatal care. Shortly after admission, convulsed and was treated with magnesium sulfate. She ired within two hours. On admission, her hemoglobin s 4.2 gm and hematocrit. 14.3. She did not receive any od transufsions. Autopsy revealed a total placenta previa. appeared that care was directed toward treatment of her eclampsia and the anemia secondary to blood loss was t appreciated.

The second patient developed a retroperitoneal hematoma er delivery. At laparotomy, the hematoma was found but t observed. To perform surgery and not make an attempt find what must have been a still actively bleeding vessel ms poor medical judgment.

The last patient had a twin pregnancy and developed eclampsia. She was scheduled for cesarean section be- se of breech presentation, but was found to have a 94,000 telet count. Surgery was delayed 24 hours while platelets re obtained (though never given). Postoperatively, the ient had a platelet count of 25,000. She had grand mal zures and an intracerebral hemorrhage and expired 14 vs later. In retrospect, the patient may have had a rarely orted expression of preeclampsia. In this group of pa- nts, the syndrome of thrombocytopenia, right upper quad- nt distress, abnormal liver function tests, and hemolysis s been described.[6] It appears that prompt delivery, treat- nt of the preeclampsia, and replacement of platelets might ve altered the tragic outcome in this patient.

COMMENDATIONS

All maternal deaths should be subject to postmortem dy. The Board of Trustees of MSNJ unanimously sup- rts this view. This recommendation has been presented to the State Board of Medical Examiners for their considera- tion.

Physicians of record in each maternal death have not been completing a case history form as requested; this is un- fortunate as the members of the Subcommittee do not have the benefit of a first-hand report of the events as they occurred. An erroneous conclusion may be reached if the chart is the only source of information.

The true incidence of cardiovascular collapse following inadvertent intravascular injection of the newer long-acting anesthetics is not known. A rarely reported syndrome of preeclampsia and thrombocytopenia with elevated liver enzymes may have contributed to one maternal death. Physicians are encouraged to report such cases and expand our knowledge of the cause and treatment of such condi- tions.

Hospital records should include all prenatal information. This is good medical practice in addition to being a require- ment of the Joint Commission on Accreditation of Hospi- tals.[7]

Every effort should be made to insure that easy access to quality maternity care is available to all women in our state. This is an obligation of physicians and should not fall on the shoulders of hospital administrators.

SUMMARY

Pregnant women continue to be well served by their physicians in our state as judged by our low maternal mortality rate of 19 per 100,000 live births. Auto accidents and drug overdose, though not maternal deaths, are prob- lems of our society that all physicians must address and help correct.

The triad of hemorrhage, sepsis, and toxemia still are causes of preventable death and must be recognized early and treated vigorously to prevent loss of life. Anesthesia for obstetrical delivery requires specialized care and awareness of the unique physiologic demands of the pregnant woman.

ACKNOWLEDGEMENTS

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25,500,000 geriatric patients. The older patient may have some disorder or socio-economic problem that can undermine good nutrition.[2]

23,500,000 surgi patients. Nutritional st can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absc tion of food.[3]



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THE MULTIVITAMIN/MINERAL FORMULATION

The Postnatal Aspiration Pattern

NORMAN MAGID, M.D., Newark*

The chest x-ray pattern of infiltrate in the right upper lobe and in the medial aspect of both lungs in a newborn or young infant should suggest aspiration. Many of the causes of this aspiration pattern in the neonate are presented with emphasis focused on their radiographic evaluation.

The value of the chest x-ray in evaluating neonatal intrathoracic disease is well established, but it also may alert the physician to disease in other organs.

DISCUSSION

One particular pattern, infiltrate in the right upper lobe and infiltration on both sides, points to postnatal aspiration.[1,2] Typical of this pattern is an infant with esophageal atresia (EA) and tracheoesophageal fistula (TEF) (Figure 1). In frontal projection, there is pulmonary opacification in the right upper lobe and also medially in the right and left lungs. This pattern suggests that aspiration has occurred in the infant while in the supine position. In the same patient, inadvertently given too much contrast medium during a supine contrast study, aspirated barium can be seen in the right upper lobe and in the inner positions of both lungs (Figure 2). Fortunately, this subsequently was cleared by coughing, but contrast aspiration should be avoided.

The causes of this neonatal postnatal aspiration pattern are numerous. The Table illustrates many of the diagnostic entities producing this pattern and divides them into two categories, common and uncommon, based upon their frequency as seen at Newark Beth Israel Medical Center.

ESOPHAGEAL ATRESIA

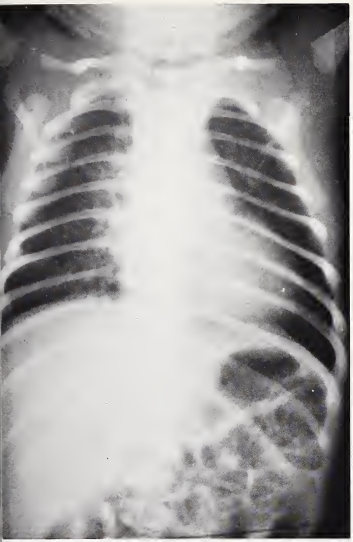
By far, the most common cause for the neonatal aspiration pattern is esophageal atresia (EA) in its various forms. The neonate with EA and TEF (Figure 3) displays the distinct pattern of infiltrate in the right upper lobe and in the me aspect of both lungs. In addition to this pattern, which is s in the entities to be discussed throughout this paper, there more specific clues of the presence of esophageal atresia. proximal pouch of the esophagus is distended and parti filled with air. This can be seen in lateral projection, bow the trachea forward. Air in the gastrointestinal tract indic a communication between the lower esophageal segment the tracheobronchial tree. Also, the upper vertebral b deformities in the thoracic spine should alert the diagn cian to anomalies in the tracheoesophageal structures.

In esophageal atresia without TEF (Figure 4), the s findings are present except that the abdomen remains gas

Most cases of esophageal atresia, recognized in the days of life, are of these two types. The rare K-type of with two fistulas (one connecting the trachea to the u esophageal pouch and the second connecting the trache the esophagus distal to the atresia) will have much the s pattern as the typical EA with one TEF to the distal pc alone.

The second rare type, esophageal atresia with a si fistula which connects the upper esophageal segment with trachea, will appear as a pure EA without fistula. Ag

*From the Department of Radiology, Newark Beth Israel Me Center where Dr. Magid is Pediatric Radiologist. Correspond may be addressed to Dr. Magid, Newark Beth Israel Me Center, 201 Lyons Avenue, Newark, NJ 07112.



ure 1—Newborn female with EA (esophageal aspiration) and
(tracheoesophageal fistula). Infiltrate is present in the right
er lobe and in the medial aspects of the supine chest x-ray.

re will be the signs of a distended upper pouch with a
less abdomen.

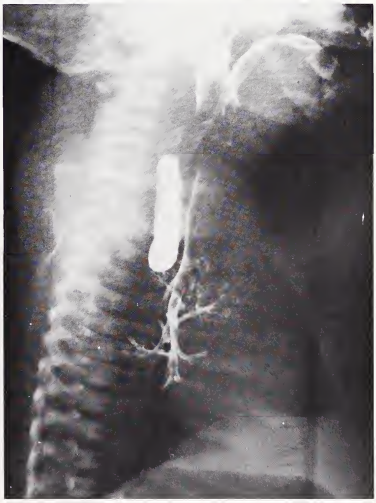
f the diagnosis of TEF and EA can be suspected from the
st x-ray study alone, is it necessary to do contrast
minations of the esophagus? Would not the presence of a
heter coiled in the proximal esophageal pouch be suffi-
nt to permit a preoperative diagnosis of EA?

The patient in Figure 5A and Figure 5B shows a typical
ture of a catheter coiled in the upper portion of the
phagus but, in a subsequent barium study (Figure 5C), a
mal esophagus is demonstrated. A contrast study is
essary both to establish the diagnosis and to exclude other
ities which mimic EA, such as a stricture. The study also
l define anatomical points such as the length of the upper
phageal pouch that will assist the surgeon in determining
optimum management of the atresia. One of the causes of
urrent aspiration after an apparently successful repair of
is the failure to identify a second fistula between the
chea and the upper esophageal pouch. To find this
ximal fistula preoperatively, a contrast examination is
essary.[3]

used judiciously and carefully in a proper preoperative
uation, the least harmful contrast material currently
ilable is barium. We advocate using a closed system
sisting of a soft feeding catheter, connected to a small
nge containing only 3 cc of barium-water mixture.[4]
owing for the dead space of the catheter, less than 3 cc
l can be injected into the esophageal pouch. The catheter
passed into the pouch and then the least amount of
trast is injected to establish the diagnosis, to determine



A



B

Figure 2—Shows AP and lateral supine chest examinations following barium contrast studies. **Figure 2A** is the AP view and **Figure 2B** is the lateral view, demonstrating the proximal esophageal pouch and subsequent aspiration of barium into the tracheobronchial tree in a distribution favoring aspiration into the right upper lobe and the medial aspect of the lungs.



A

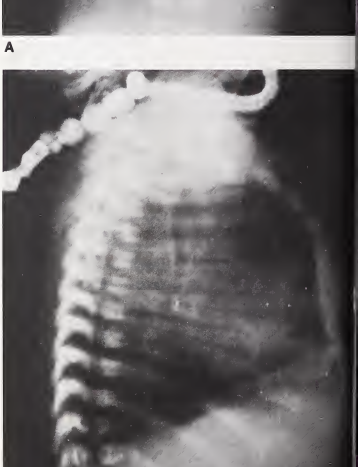


B

Figure 3—Newborn male with TEF and EA. **Figure 3A** is a frontal view of the chest demonstrating the aspiration pattern of infiltrate in the right upper lobe and medial aspects of the lung and multiple vertebrae body anomalies. **Figure 3B** shows the lateral view demonstrating partial air distension of the proximal esophageal pouch producing anterior bowing of the trachea.



A



B

Figure 4—Newborn female esophageal atresia without fistu
Figure 4A is the AP supine view; infiltrate is present in ri
upper lobe and left upper lobe as well as medially in both lun
No gas is visualized in the abdomen. **Figure 4B** shows late
supine view revealing bowing anteriorly of the trachea a
posterior to this is air in the proximal esophageal pouch.



Figure 5—Newborn male with false positive coiled catheter sign. **Figure 5A** is the frontal view and **Figure 5B** is the lateral view of the chest; both reveal clear lungs and tube that is coiled in the proximal esophagus suggesting esophageal atresia. However, a subsequent barium esophagogram **(Figure 5C)** demonstrates a normal esophagus. Note that the aspiration pattern is not present in the chest x-ray.

the length of the upper esophageal segment, and to exclude the presence of an upper esophageal fistula to the trachea. Once this has been accomplished, the barium then is aspirated from the pouch and the catheter withdrawn. This technique minimizes the risk of aspiration. Figure 6 demonstrates the value of this system. There is the elongated pouch extending below the carina and passing to the right of the midline. This is not the proximal pouch pattern usually seen in TEF with EA, which does not extend to the level of the carina. It represents a rare type of fistula associated with a lower level of esophageal atresia, a communication between the right bronchus and the esophagus distal to the atresia.

In Figure 7A and Figure 7B, the chest x-ray of a two-month-old infant suggests aspiration pneumonia and an abdominal study displays marked gastrointestinal meteorism. An earlier barium esophageal study demonstrated contrast material in the tracheobronchial tree; but a fistulous communication could not be established. This case is typical of an H-fistula (tracheoesophageal fistula without esophageal interruption), presenting with feeding difficulties, recurring bouts of pneumonia, and inconclusive esophageal study. The aspiration pattern is due to the fistula; the marked meteorism in the gastrointestinal tract reflects the pressure relationships between the esophagus and trachea, with air usually passing from the trachea through the fistula into the esophagus and subsequently being swallowed.[5]

The demonstration of the H-type fistulous communication between the trachea and the esophagus is difficult. It is important in the differential diagnosis to establish that contrast material passes into the trachea, via the fistula, and is not aspirated from above. The method I have found most helpful is to pass a feeding catheter into the stomach and then to inject barium contrast as the catheter is withdrawn in stages. First, the catheter is withdrawn to the level of distal esophagus and a small amount of contrast material is injected; this is repeated at mid and upper levels of the esophagus. Usually at the level of the mid or upper thoracic esophagus a small amount of contrast material will be seen passing through the fistula into the trachea. The lateral view is the best one to demonstrate the fistula.[7] As in Figure 7C, the contrast medium passes from the proximal thoracic esophagus to the trachea in a cephalad and anterior direction.The "H" of the H-fistula is a misnomer; a better term would have been an N-fistula.

SWALLOWING INCOORDINATION

The second most common cause for the neonatal aspiration pattern is poor coordination of swallowing which is illustrated in Figure 8A. This usually is seen in premature infants and fortunately it is a transient phenomenon.[8] Typically, in the pattern of swallowing with poor coordination, there is prominent reflux of barium into the nasal cavity. There may or may not be a small amount of barium aspirated into the trachea (Figure 8B). This transient incoordination (in an otherwise normal infant) can be expected to disappear as the child develops. If it persists, it probably reflects an underlying disease such as brain damage, neuromuscular disease, familial dysautonomia, or other conditions. These are all much rarer causes of disordered swallowing.

There are many causes for the postnatal aspiration pattern (Table) which are seen infrequently.[6] In Figure 9A, a child with a hiatal hernia displays massive reflux of barium into the esophagus. The initial chest x-ray on this child was normal. At two months of age, he was readmitted to the

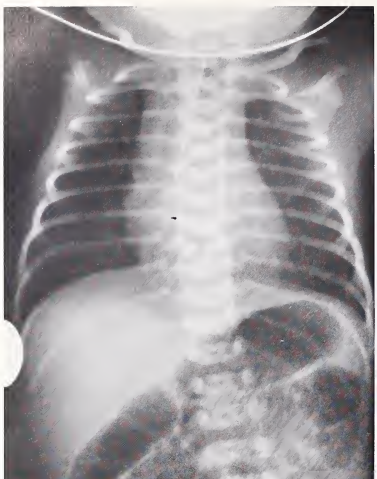


Figure 6A—Newborn female with low esophageal atresia and a bronchoesophageal communication uniting the right bronchus to lower esophageal segment; this is the AP view.

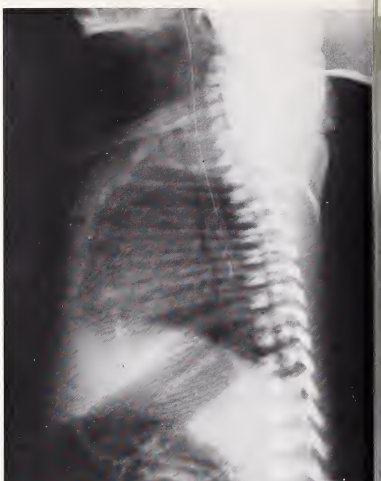


Figure 6B—This is the lateral chest view demonstrating the nasogastric catheter extending below the carina and to the right of the midline.

hospital with the typical aspiration pattern (Figure 9B). One must emphasize the reflux and aspiration also can be produced by partial obstruction in the upper gastrointestinal tract such as duodenal stenosis or hypertrophic pyloric stenosis. This should be kept in mind in evaluating infants with the aspiration pattern. Delayed films of the abdomen, following contrast examination of the esophagus have shown

TABLE

Causes of the Postnatal Aspiration Pattern

Common Causes:

1. Esophageal atresia and/or tracheoesophageal fistula.
2. Transient pharyngeal incoordination in premature infants.

Uncommon Causes:

1. Other esophageal obstructive lesions (partial or complete): webs, strictures, or vascular rings.
2. Obstructions of the proximal GI tract (pyloric stenosis, duodenal atresia, or stenoses).
3. Diseases associated with difficulty in swallowing or esophageal incoordination: familial dysautonomia; Pierre Robin syndrome; and neuromuscular disease.
4. Fistulas between tracheobronchial tree and the gut.
5. Esophageal reflux associated with a hiatal hernia.
6. Improperly placed nasogastric feeding tubes.
7. Pseudodiverticulum of the pharynx (iatrogenic perforation of the pharynx in the neonate).

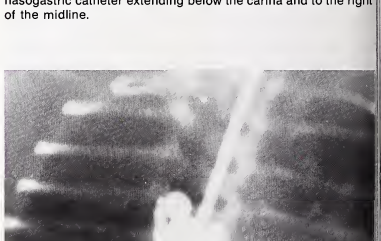


Figure 6C—This reveals barium injected via the catheter confirming the elongated pouch of the proximal esophageal atretic segment. Air in the abdomen is due to the fistulous communication between the right main stem bronchus and the distal esophageal pouch.

partial obstruction of the proximal gastrointestinal tract.

Another uncommon cause for the aspiration pattern is congenital pseudodiverticulum of the pharynx. This results from the inadvertent passage of a catheter through the posterior wall of the pharynx.[9] In Figure 10, there is a long pouch posterior to the pharynx, that was produced by the improper passage of a catheter. In the three cases of



A



B



C

Figure 7—A 2-month-old male, with H-type TEF. AP supine chest shown in **Figure 7A** demonstrates the aspiration pattern of infiltrate in the right upper lobe and medial aspect of both lungs. **Figure 7B** reveals supine chest and abdomen illustrating the considerable gaseous distension of the bowel. A spot film of the barium esophagogram obtained in sharp oblique projection **(Figure 7C)** reveals the catheter in the esophagus and contrast material passing into the trachea via a thin fistula which extends from the esophagus to the trachea in an anterior and cephalad course.

pseudodiverticulum in our files, incoordination of swallowing was present with prominent nasal reflux.

SUMMARY

The postnatal aspiration pattern, pulmonary infiltrate in the right upper lobe and the medial aspect of the right and left lungs, has been a valuable clue in the recognition of patients with swallowing difficulties in the neonatal period. The most common cause for the postnatal aspiration pattern is esophageal atresia in its various manifestations. The second most common cause is transient esophageal incoordination which is seen in premature infants. The chest x-ray examination, combined with the clinical background and the careful and judicious use of contrast media examinations, will allow a definitive diagnosis of most of these entities.

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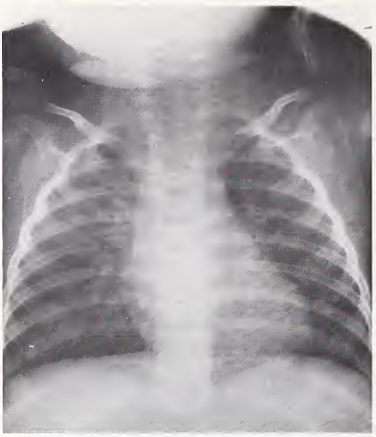
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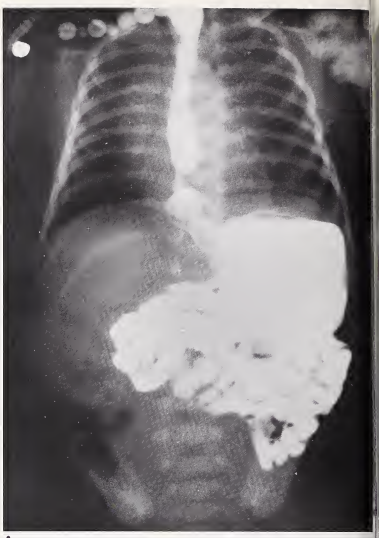


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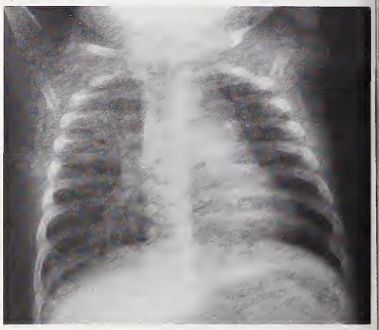


B

Figure 8—Newborn female with transient incoordination of swallowing. **Figure 8A** is the supine chest demonstrating aspiration pattern, and **Figure 8B** shows spot film obtained in barium esophageal study showing prominent nasal reflux of barium and aspiration of barium into the trachea.



A



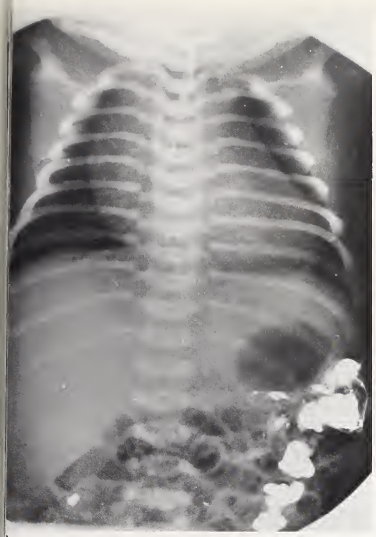
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Figure 9—Hiatal hernia associated with prominent gastroesophageal reflux. **Figure 9A** is supine chest and abdomen obtained during upper gastrointestinal study at one month. Marked reflux barium outlines both hiatal hernia and extends above it to the cervical esophagus. Supine chest at age two months **(Figure 9B)** following a bout of severe aspiration shows the aspiration configuration of right upper lobe infiltrate and infiltrate in the medial aspect of the lungs. Infiltrate also is present in the left upper lobe, a pattern which also can be seen, though less frequent, in the aspiration syndrome.

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A



B



C

Figure 10—Newborn male with pseudodiverticulum of the pharynx. **Figures 10A** and **10B** are lateral views of the chest, revealing a catheter posterior to the trachea. An initial impression might be esophageal atresia with the catheter located in the proximal pouch of the atretic esophagus. On closer scrutiny, the catheter in the neck is separated from the trachea by an air-containing tubular structure which represents the esophagus. **Figure 10C** showing spot films obtained during fluoroscopy demonstrates a pseudodiverticulum arising from the posterior wall of the pharynx and extending posterior to the esophagus. Prominent nasal reflux of barium during swallowing also was present.

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PROCARDIA® CAPSULES For Oral Use
(nifedipine)

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-assosciated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS. General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with rechallenge in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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"I can do things that I couldn't do for 3 yrs. including joining the human race again."



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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks, taking fewer nitroglycerin tablets, doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients; transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

cardia is indicated for the management of:
Confirmed vasospastic angina.
Angina where the clinical presentation suggests a possible
ospastic component.
Chronic stable angina without evidence of vasospasm in
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Please see PROCARDIA *brief summary on adjoining page.*

Transfontanelle Real-Time Ultrasonography of the Neonatal Head: A Prospective Study

MICHAEL WOLFSON, M.D., WALTER S. ROSE, M.D.,
I. MARK HIATT, M.D., THOMAS HEGYI, M.D., Long Branch*

Transfontanelle real-time ultrasonography performed on 49 neonates and infants was investigated. Intracranial hemorrhage was the most frequent finding. In those cases where computed tomography (CT) correlation was available, ultrasound was 85 percent sensitive and 92 percent specific in detecting intracranial hemorrhage. Also, ultrasound accurately detected complications following intracranial hemorrhage, as well as other unrelated intracranial abnormalities with a specificity of 100 percent. Transfontanelle ultrasonography, therefore, is recommended as an alternative diagnostic method for detection and followup of neonatal intracranial hemorrhage.

In the evaluation of the neonatal brain, computerized tomography (CT) scanning currently is the method of choice for detection of intracranial pathology. However, its use in premature or very ill infants is hampered by the problems of transport, temperature control, and respiratory support. In addition, serial CT scanning can subject these patients to significant radiation exposure.

Recent advances in ultrasound technology allow studies to be performed in the intensive care nursery, eliminating many of the problems associated with CT scanning. This, plus the fact that ultrasound does not involve ionizing radiation, makes ultrasound an attractive potential alternative. Transfontanelle real-time ultrasonography produces images of sufficient detail to detect intracranial hemorrhage and its complications, as well as other unrelated intracranial lesions. In studies comparing ultrasound with CT, results have been favorable.[1-6]

A prospective study of transfontanelle real-time ultrasonography in neonates was performed to determine its accuracy in detecting intracranial pathology.

MATERIALS AND METHODS

Over a period of five months, 79 real-time sonograms were performed in 49 infants with birth weights ranging from 700 to 4,860 gm (gestational ages of 25 to 43 weeks) using the transfontanelle technique.[7]

Stated simply, the anterior fontanelle represents a "natural" acoustic window. With the ultrasound transducer placed on the anterior fontanelle, angling the transducer in coronal and sagittal planes will produce high resolution images of the brain and the ventricular system.

All examinations were performed in the intensive care nursery using an Advanced Technology Laboratory MK 300C real-time sector scanner with a multifrequency transducer having a 90 degree field of vision. Most examinations

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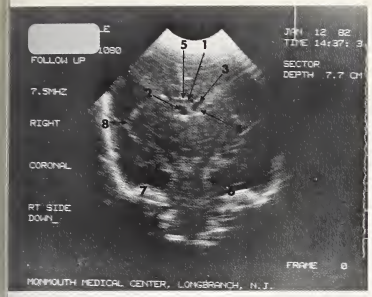


Figure 1—Normal coronal anatomy.

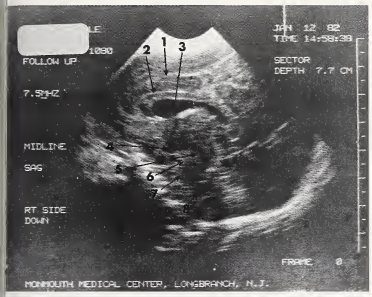


Figure 2—Normal midline scan.

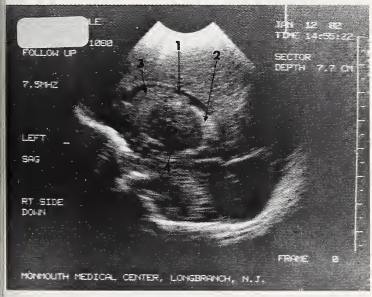


Figure 3—Normal sagittal anatomy.

were performed with the 7.5 MHz frequency. Images were recorded using an ATL 130-A line scan recorder on dry silver paper. Each examination included angled coronal, midline, and parasagittal views following the method described by Shuman.[7] When infection was suspected, the transducer head was covered with a sterile rubber glove. Each sonogram was performed with the patient in an Isolette® under warming lights or through the arm portholes.

TABLE 1
Sonographic Findings

Ultrasound Diagnosis	No.	CT Performed
Hemorrhage*	11	6
Subependymal	2	
Intraventricular	5	
Cerebral	5	
Congenital hydrocephalus	2	2
Hydranencephaly	1	1
Vein of Galen AVM**	1	1
Arnold-Chiarl malformation	1	0
Cerebral edema	1	1
Normal	32	9
Total	49	20

*Includes 1 patient with initial subependymal hemorrhage with subsequent intraventricular hemorrhage.
**Vertebral arteriography was performed.

Most infants were studied for the presence of intracranial hemorrhage; a few were studied for other suspected congenital or acquired lesions. During the latter part of this study, ultrasound examinations were performed routinely, on all preterm infants weighing 1,500 gm or less.

All ultrasound examinations were performed and interpreted by Drs. Wolfson and Rose. Comparison of sonographic findings with those of CT was made on all infants having both studies within 24 hours of each other. CT scans were performed on an Ohio Nuclear Delta 50 FS 18-second total body unit and were interpreted by members of the radiology staff. Intravenous contrast scans were obtained in some instances when indicated.

RESULTS

Of the 49 patients examined, 20 had CT scans performed within 24 hours of sonography. These patients form the main body of this report (Table 1).

Figure 1 demonstrates the normal coronal anatomy with the transducer angled approximately 80 degrees to the canthomeatal line towards the sella. Hypoechoic structures seen include: the corpus callosum (1), cavum septum pellucidum (2), and the lateral ventricles (3). The caudate nucleus (4) is of medium echogenicity. The pericallosal (5) and internal carotid (6) arteries also are identified, appearing pulsatile on the real-time scan as are the middle cerebrals (7) branching within the Sylvian fissure (8).

The normal midline anatomy (Figure 2) demonstrates the callosal marginal (1) and pericallosal (2) arteries, cavum septum pellucidum, and cavum verge (3), the third ventricle (4), the cerebral aqueduct (5), the midbrain (6), pons (7), and medulla (8).

In the sagittal plane (Figure 3) with the transducer angled toward the inferior portion of the temporal lobe, the lateral ventricle (1), choroid plexus (2), caudate nucleus (3), and thalamus (4) are demonstrated.

CT scan revealed intracranial hemorrhage (ICH) (Table 2) in 7 of 20 patients examined. Ultrasound detected 6 ICHs, for a sensitivity of 85 percent. Sonographic findings include 3 patients with cerebral hemorrhage (Figure 4) and 2 patients with intraventricular hemorrhage (Figure 5). One patient initially had a subependymal hemorrhage and subsequently developed an intraventricular hemorrhage (Figure 6). The one false negative study occurred in a patient with an isolated subarachnoid hemorrhage on CT examination.

TABLE 2

Ultrasound Detection of Intracranial Hemorrhage

Ultrasound Diagnosis	CT Diagnosis: No. Hemorrhage	CT Diagnosis: Hemorrhage	Total
No. Hemorrhage	12	1	13
Hemorrhage	1	6	7
Total	13	7	20

Sensitivity = 85 percent (6/7)
Specificity = 92 percent (12/13)

TABLE 3

Ultrasound Detection of Abnormality Other than Hemorrhage

Ultrasound Diagnosis	CT Diagnosis: Normal or ICH*	Abnormality	Total
Normal or ICH*	11	4	15
Other abnormality	0	5	5
Total	11	9	20

Sensitivity = 55 percent (5/9)
Specificity = 100 percent (11/11)
*Intracranial hemorrhage

There was one false positive ultrasound which suggested a subependymal hemorrhage in a patient with a negative CT, for a specificity of 92 percent (12/13). Sonography also detected several complications of intracranial hemorrhage including hydrocephalus (Figure 7), porencephaly (Figure 7), and ventricular septations (Figure 8).

CT scan detected abnormalities other than intracranial hemorrhage in 9 patients (Table 3). Sonography detected 5 of these abnormalities for a sensitivity of 55 percent. These included 2 patients with congenital hydrocephalus (Figures 9 and 10), 1 patient with hydranencephaly, 1 patient with a Vein of Galen AVM (Figures 11 to 14), and 1 patient with cerebral edema. In the remaining 4 patients, CT showed cerebral edema or encephalomalacia in 2 patients, toxoplasmosis with intracranial calcifications in 1 patient, and bilateral, peripheral, cystic lesions in the occipital lobes in a patient with *E. coli* meningitis. There were no sonograms falsely positive for abnormalities other than intracranial hemorrhage, for a specificity of 100 percent (11/11).

In 5 additional patients in whom CT scans were not performed, sonography suggested intraventricular hemorrhage in 2 patients, cerebral hemorrhage in 2 patients, and an Arnold-Chiari malformation (Figures 15 and 16) in 1 infant with myelomeningocele. Three of these patients died. One patient was lost to followup. The remaining patient with an Arnold-Chiari malformation survived. Thus, the clinical course supports the sonographic evidence of intracranial pathology in these infants.

Among the 16 patients with abnormal CT scans, ultrasound detected 11 abnormalities, for an overall sensitivity of 69 percent (Table 4). There was one false positive ultrasound, for a specificity of 75 percent.

DISCUSSION

Since the application of CT scanning in preterm neonates weighing 1,500 gm or less, intracranial hemorrhage has been found to occur in 43 to 70 percent of neonates.[6,9] Because modern therapy often permits survival beyond the newborn period for these infants, increasing emphasis has been placed on detection of these hemorrhages and their severity so that appropriate management decisions can be made.

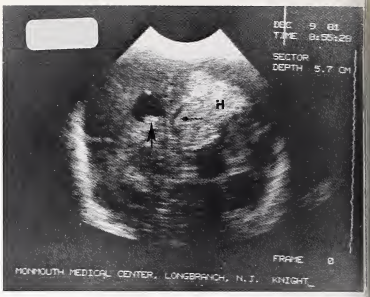


Figure 4—Coronal scan shows small echogenic blood clo within the dilated lateral ventricle (large arrow). The small arrov indicates blood within the ventricle and a large subependyma hemorrhage. In addition, there is a large echogenic cerebra hemorrhage into the white matter (H).

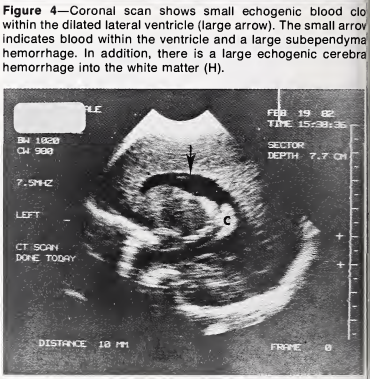


Figure 5—Sagittal scan demonstrates a clot (C) within an enlarged ventricle (arrow).

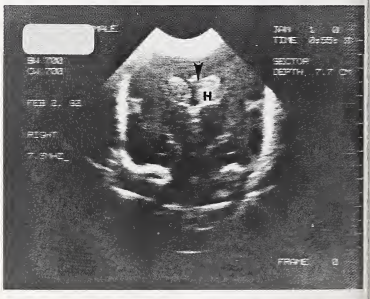


Figure 6—Coronal scan shows a large bilateral subependymal hemorrhage (H) that has ruptured into the lateral ventricle (arrowhead).

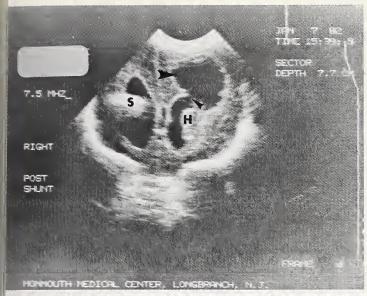


Figure 7—Coronal section demonstrates hydrocephalus (large arrows) with a shunt tube (S). There is a porencephalic cyst (large arrowhead) which communicates (small arrowhead) with the lateral ventricle. Note echogenic clot (H) within the lateral ventricle.

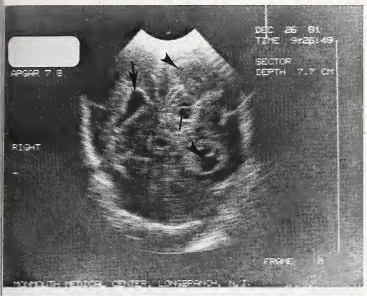


Figure 8—Coronal scan shows a ventricular septation (small arrow). There is a resolving cerebral hemorrhage (top arrowhead) surrounded by a thick echogenic rim which will become an area of porencephaly as seen inferior to this area (lower arrowhead). The right lateral ventricle is dilated (large arrow).

The spectrum of intracranial hemorrhage is variable. The hemorrhage may remain limited to the subependymal germinal matrix or extend into the ventricular system, in which case obstructive hydrocephalus may result. Cerebral hemorrhage may lead to the formation of porencephalic cysts which communicate with the ventricle.[10] The long-term relationship of the severity of the hemorrhage to prognosis currently is under investigation. Recent studies on the use of real-time ultrasonography suggest that ultrasonography can detect intracranial hemorrhage with sensitivity generally greater than 85 percent,[1] approaching in some reports that of CT.[3-5] False negative sonograms have occurred in infants with subarachnoid hemorrhages,[5] very small subependymal hemorrhages,[11,12] and choroid plexus hemorrhages documented by CT.[4] False positives can occur as a result of misinterpretation, in particular, mistaking the choroid plexus for subependymal or intraventricular blood. This pitfall can be avoided by careful correlation of coronal with sagittal sections.[13] Another source of false positivity is the problem of isodensity of blood on CT scan. CT scan may not detect

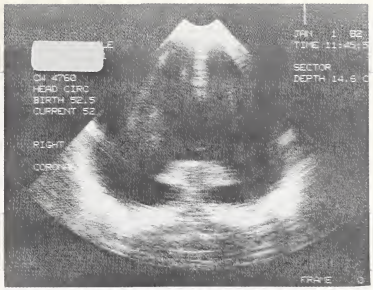


Figure 9—Coronal section in an infant with congenital hydrocephalus demonstrates massively dilated, anechoic lateral ventricles.

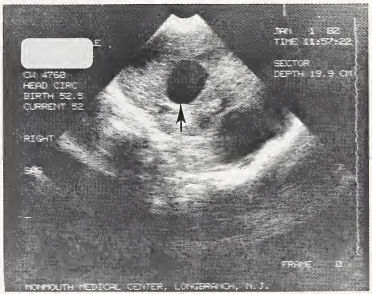


Figure 10—Midline section of the same patient in Figure 9. The third ventricle (arrow) is enlarged without evidence of a cerebral aqueduct.

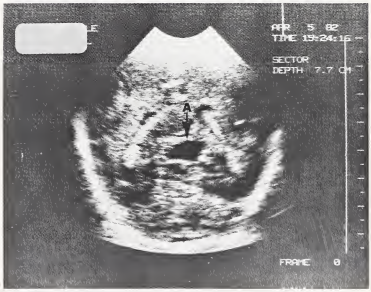


Figure 11—Coronal section demonstrates a pulsatile cystic area (A) which CT (Figure 13) and arteriography (Figure 14) proved to be a Vein of Galen aneurysm.

old isodense hemorrhages that are detected by ultrasound because of the differing physical properties imaged by the two modalities.[2] Thus, these "false positive" sonograms in

TABLE 4

Ultrasound Detection of Intracranial Pathology

Ultrasound Diagnosis	CT Diagnosis Normal	Abnormal	Total
Normal	3	5	8
Abnormal	1	11	12
Total	4	16	20

Sensitivity = 69 percent (11/16)
Specificity = 75 percent (3/4)

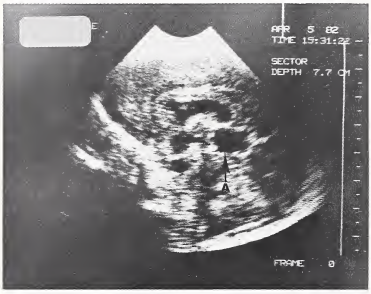


Figure 12—Midline sagittal section of same malformation in Figure 11.

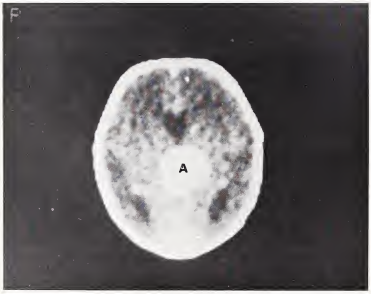


Figure 13—CT with contrast shows a Vein of Galen aneurysm (A).

reality may represent false negative CT scans and, in fact, this explanation probably accounts for the one false positive sonogram in this series.

The results of this study compare favorably with others for the detection of intracranial hemorrhage, its degree, and its complications.[1-6] In this series, sonography was 85 percent sensitive and 92 percent specific in detecting or excluding intracranial hemorrhage based on CT findings.

Real-time ultrasonography also has identified accurately a variety of abnormalities other than intracranial hemorrhage, including Dandy-Walker cysts, arachnoid cysts, subdural hematomas, subdural hygroma, encephalocele, toxoplasmosis, lipoma of the corpus callosum, congenital absence of



Figure 14—A vertebral arteriogram was performed and demonstrated the AVM (A) being supplied by the posterior cerebral circulation.

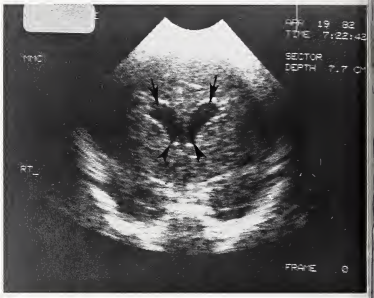


Figure 15—Coronal section of a patient with myelomeningocele and an Arnold-Chiari malformation. The ventricles are enlarged (arrows) and there is inferior pointing of the frontal horns (arrowheads).

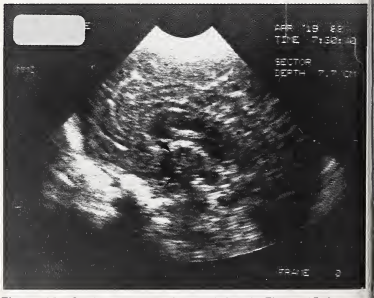


Figure 16—Sagittal section of same infant in Figure 15 demonstrates an enlarged massa intermedia (arrows).

he corpus callosum, and tumor.[3,14] Sonography appears, ıowever, to be limited in identifying cerebral edema or :ncephalomalacia.[15,16] In addition, intracranial calcifications nay be missed, as may occipital or cerebellar lesions because of their position with respect to the anterior fontanelle. In his series, sonography was 55 percent sensitive and 100 ercent specific in the detection of abnormalities other than ıemorrhage, the false negatives occurring in patients with esions similar to those described above. It should be noted hat cerebral edema often is difficult to detect on CT as vell,[15] since there are as yet no specific CT criteria for its dentification in neonates. In the one case where sonography letected cerebral edema there was a loss of structural lefinition of the normal anatomy, while CT demonstrated an ıpparent reversal of the gray-white matter pattern of at-enuation consistent with edema. At the present time, it robably is best to use such criteria with caution. Further nvestigation in this area is needed.

"The advantages of ultrasonography include portability, lower cost, and absence of ionizing radiation."

The advantages of ultrasonography include portability, ower cost, and absence of ionizing radiation. The examina-ions can be performed at the cribside with minimal handling of the infant, eliminating the potential morbidity associated vith transport and the handling required for CT scanning. Many infants, in fact, cannot safely leave the intensive care ıursery, and it is in these cases that ultrasonography may rove indispensible in diagnosing intracranial hemorrhage ınd its complications.

CONCLUSION

Transfontanelle real-time ultrasonography is a safe and ıccurate method of evaluating the neonatal brain when ntracranial hemorrhage is suspected, and is a viable alter-ıative to CT. While CT perhaps is more sensitive in detecting certain other abnormalities, sonography promises to be an important diagnostic tool for these as well.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia, particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Home Care Delivery in Bergen County in the 19th Century

TEWART F. ALEXANDER, M.D., and
IICHAEL A. NEVINS, M.D., Park Ridge*

A study of the detailed, handwritten obstetrical records of Henry C. Neer, M.D., in the course of his active, rural community medical practice gives a clear and interesting reflection of medical practice at that time.

Henry C. Neer, M.D., (1838-1911) was the Pascack Valley's first physician; he established a practice in ark Ridge, then known as Pascack, in 1865. In the postivil War period, Park Ridge was a rural community in the ortheastern portion of Bergen County. In fact, Park Ridge ad no corporate identity and was more of a settlement or amlet whose basic strength was in the old original Dutch ettlers augmented by immigrant farmers and artisans. Dr. leer's practice remained in continuous service until 1980.)r. Samuel Alexander (1888-1952) succeeded Dr. Neer. Dr. lexander initially lived with the Neer family; in turn, he was ollowed in the practice by his son, the senior author of this aper. In reviewing some of the original records of that ractice, the experience of obstetrical home care of a century go seemed worthy of recording.

Dr. Neer (Figure 1) spent the first five years of his rofessional life in East Brunswick, New York, before noving to Park Ridge. He was a multitalented man and a ompetent, innovative, and dedicated physician. An acomplished musician, he sang in the church choir and, ndeed, the church was known as "Dr. Neer's church." He vas an inventor and held several legitimate patents, includng one for a pill-coating machine. In addition, he was a harmacist, the local health officer, a piano salesman, mayor f the town after it was incorporated in 1894, and three times resident of the Bergen County Medical Society. A friend of ll he encountered, Dr. Neer was a paragon of the family physician, a living example of the famous portrait by Sir Luke Flades.

Dr. Neer's daily professional activities were recorded in several huge ledgers; a study of which provides a unique insight into the nature of 19th century country practice. This report deals with one ledger that records more than 2,000 obstetrical deliveries performed by Dr. Neer in local farmhouses (Figure 2). In addition to citing vital statistics, this handwritten ledger meticulously documents details of the more complicated cases in which delivery was difficult or in which there were congenital malformations, tumors, seizures, and renal or vascular problems. How he lived with, pondered, and solved this gamut of trials is fascinating. Dr. Neer's vital statistics in many cases were the only records whereby essential data were available, and calls for reference to it were being made until very recent years.

A man of few words, Dr. Neer was an extremely accurate observer and detailed recorder. His interest in human nature was revealed in occasional terse remarks such as a comment that a 13-year-old black girl was his youngest obstetrical patient, or that the husband of one mother was a Baron in Holland who had run away with his mother's seamstress. Superstitions and misconceptions of the time clearly are identified in the narratives.

*Presented at the Medical History Society of New Jersey Annual Symposium, May 12, 1982. Correspondence may be addressed to Dr. Alexander, 108 Pascack Road, Park Ridge, NJ 07656.



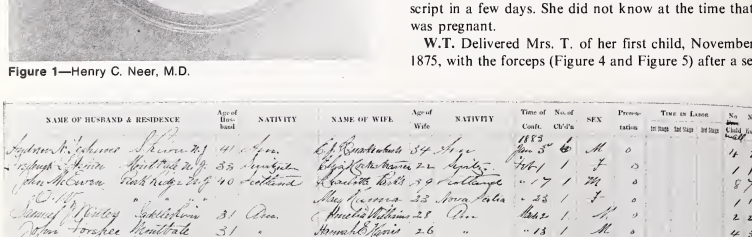
Figure 1—Henry C. Neer, M.D.

SELECTED EXTRACTS

W.M. My second case. Deformed pelvis. Contraction anteroposterior. Labor progressed favorably until the head was freed from the uterus. The patient, a strong, muscular woman, was in terrible agony, the pains being the most terrific I ever saw. Extreme exhaustion setting in rapidly, and the child evidently being dead, I performed craniotomy and delivered with blunt hook (Figure 3). Dr. E. Bigelow, who had been sent for, arrived soon after and confirmed the diagnosis of deformity and commended the treatment. Recovery was rather tedious but perfect.

W.V. Delivered of a monstrosity, the form of which was as follows: the upper portion of the child was perfectly developed. The femurs crossed each other, bringing the outside of the legs together, the whole being perfectly united from the hips to the toes. The knees were grown smoothly together, the two joints could be located, partially flexed with limited motion, the ankles completely merged into one. There were neither genitals nor anus. The thigh, or thighs, was flexed upon the abdomen, and pulled away would spring back like India rubber, the nates forming a smooth, round, conical form resembling a well-shaped stump. This case, occurring during one of the first conscriptions, was undoubtedly caused by nervous impressions on the mind of the mother, a very sensitive and imaginative person, produced by seeing a man at a show who had had both thighs amputated in the army, and expectations that her husband might be a conscript in a few days. She did not know at the time that she was pregnant.

W.T. Delivered Mrs. T. of her first child, November 27, 1875, with the forceps (Figure 4 and Figure 5) after a severe



NAME OF HUSBAND & RESIDENCE	Age of Husband	NATIVITY	NAME OF WIFE	Age of Wife	NATIVITY	Time of Conft.	No. of Ch'd'n	SEX	Presentation	Time in Labor 1st Stage	2nd Stage	3rd Stage	No. Child living	No. Still Born	No. Miscarriages
						1855									
Stephen N. Johnson	Farmer	N.J.	Eliz. Rosenbrook	54	Virginia	June 5th	6	M	O				4	2	
Joseph Stine	Hatter	N.J.	Eliza Ann Mackey	22	England	Feb 1	1	F	O				1	1	
John McEwan	Brickmaker	Scotland	Charlotte Smith	29	Scotland	" 17	1	M	O				8	7	
"	"	"	Mary Ramsey	23	Nova Scotia	" 23	1	F	O				1	1	
Samuel J. Darby	Gentleman	Ohio	Amanda M. Williams	25	Ohio	March 2	1	M	O				2	2	
Orson Fowler	Merchant	31	"	Hannah E. Jones	26	"	" 13	1	M	O			4	3	
Charles Gutzmer	Engineer	34	Germany	Susanna Ackerman	36	Wisconsin	" 18	1	M	O			5	4	
Peter M. Ryman	Brickmaker	N.J.	42	Ohio	Margaret Ann Bell	39	Ohio	April 6	1	F	O		10	8	
Peter Stone	Schoolteacher	40	"	Charlotte Curtis	38	"	" 16	1	F	O			4	4	
Jacob Warren	Gentleman	Pennsylvania	33	"	Ella J. Simpson	24	"	" 27	1	F	O			1	1
Edward Ackerman	Gentleman	N.J.	43	"	Elizabeth Campbell	34	"	" 28	1	F	O			6	5
Samuel Varley	Gentleman	N.J.	26	Canada	Sarah Ann Ford	37	England	" 29	1	F	O			1	1
Henry Rose	Merchant	28	Ohio	Catherine Jane Meeks	27	Ohio	May 30	1	F	O			1	1	
Isaac Kuykendall	Millwright	22	"	Adelaide Harvey	24	"	" 5	1	M	O			2	2	
Wm. McKeppen	Shoemaker	24	"	Rachel Crowther	19	"	" 27	1	M	O			1	1	
Hon. W. Ackerman	Gentleman	N.J.	36	"	Margaret Elizabeth Ackerman	34	"	" 27	1	F	O		1	1	
Elijah Johnson	Gentleman	S. Carolina	38	"	Eliza Ann Hendricks	29	"	" 30	1	M	O		3	3	
Henry Ackerman	Gentleman	36	"	Margaret Whitesell	22	"	June 3	1	F	O			2	2	
John Van Gilder	"	28	"	Hannah Brown	23	"	" 3	1	M	O			4	2	
Theodore Apgar	Merchant	39	"	Hannah M. Ackerman	38	"	" 15	1	F	O			6	4	
Abraham Johnson	"	47	"	Sarah J. Van Horn	37	"	July 8	1	M	O			7	3	
Jos. Ackerman	Gentleman	Park Ridge N.J.	29	"	Rachel Ackerman	27	"	" 7	1	F	O		4	4	
Wm. Sanders	"	32	"	Ann A. Smyth	19	"	" 18	1	F	O			8	2	
Johnathan A. Ackerman	Merchant	31	"	Georgiana B. Sage	23	"	Aug 4	1	F	O		36hrs	1	1	
Peter Van Emburgh	Farmer	26	"	Ella E. Haring	26	"	" 8	1	M	O			8	2	
Garret J. Post	Gentleman	31	"	Catharine M. Engelish	20	"	" 22	1	F	O			1	1	
Horace A. Smith	Park Ridge N.J.	29	"	Mary R. Bennett	28	"	" 24	1	F	O			5	5	
Jacob Fehr	Spring Valley N.J.	32	Germany	Mary M. Taylor	28	"	" 27	1	M	O			3	2	
Peter Boekhout	Farmer	33	Holland	Hattie A. Hallman	30	"	Sept 25	1	F	O			1	1	
Cornelius A. Ackerman	Millstone N.J.	39	Ohio	Nellie A. Van Millen	28	Holland	Oct 1	1	M	O			8	8	
			Ruth A. Coleman	38	Ohio	" 5	1	F	O				3	2	

Figure 2—Half page of Dr. Neer's obstetrical records.

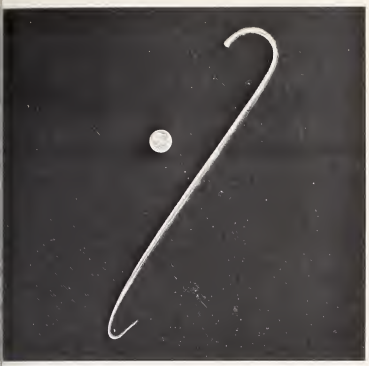


Figure 3—Dr. Neer's blunt hook.

abor of several hours. She was very much exhausted, in a ervous and debilitated condition, and recovery was slow, vith an attack of metritis and a mild attack of phlegmasia olens. This second labor was unmarked by anything unsual, unless it was the severity of the pains and the great ressing efforts made by the patient; labor progressing avorably the head and the whole child being expelled by an ffort. Having tied the cord, I placed my left hand on the bdomen to ascertain the condition of the uterus which I ound lying quite low down in the pelvis and the fundus very uch depressed. Introduced my finger into the vagina and ound the placenta had not yet presented itself at the os. Making slight friction over the womb, I directed the patient o press down when the pain came on so as to assist in the xpulsion of the placenta. A strong contraction soon came n and the patient seized by a strong desire to strain, and the vomb with its contents in a moment's time was lying outside he vulva, the uterus completely inverted with the placenta nd membranes all attached. Discovering immediately the ature of the accident, I quickly freed the womb from the ttached placenta and shutting my fingers over my thumb so s to make as smooth and conical a fist as possible, placed it n the inverted fundus and quickly replaced the womb to its ormal position, being sure no depressions were left in the terine walls. The whole time occupied from its expulsion to s perfect restoration could not have exceeded two minutes. he patient made a quick and excellent recovery.

J.H. Mrs. H. was delivered the first time, July 15, 1867, of wins, a male and female. The latter subsequently died of anition. Eclampsia, in a very severe form, set in before the vomb was fully dilated. Dr. Banta was called in consultaon. The child was delivered with the forceps, and as soon as racticable the second one also was delivered with the orceps. The hemorrhage was terrible but finally was conrolled by the free use of stimulants, ergot, cold, and ompression. The convulsions gradually became less freuent after delivery, ceased after 36 hours, and the patient ade a good though slow recovery. December 18, 1870, she ave birth to another pair of twins, the labor being natural. etween that and this time she gave birth to a child in aterson, making seven children in four labors.

A.C. Uterine debility and exhaustion. Dr. Simpson in consultation. Child high in the abdomen wall, os dilated but no descent. After several ineffective efforts to apply forceps, delivered by podalic version. Convalescence slow but apparently good until the 13th day when she was suddenly seized with pain in side and died in a few moments.

W.B. Was called early in morning about 5 A.M. Found mother dead. Both infants lying between her thighs still attached to the placenta. She had heart disease for years and came near dying in her first labor which occurred in New York City. Death probably was the result of heart failure.

G.S. In the fall of 1871, was called to see Mrs. S., who had been taken with pain and flowing, and feared a miscarriage. She said she was about six months pregnant. The hemorrhage having all ceased before my arrival and her condition not seeming to require it, I did not make an examination, but requested to be immediately informed if it recurred. In the beginning of January, 1872, was called again, but as before the hemorrhage had been small in quantity and had ceased before my arrival, and no examination was made. January 21, was called again in the evening and found her having regular, moderate pains with slight hemorrhage, said it was time for her to be confined. On making an examination, found the uterus but very slightly enlarged and a soft mass presenting at the os which would just admit the finger. I told her she was not pregnant, that it was probably a mole. She persisted, however, that she was, that she had had all the symptoms of it and had felt life as distinctly as in her previous pregnancy. The breasts were enlarged and the areola and nipples unusually dark. The labor progressed and the womb soon expelled a pyramid-shaped mass having all the appearance, structure, and consistency of a placenta. The upper right corner was ragged and torn as if the cord had been pulled off. The hemorrhage was about as it would be in a natural labor. The mass expelled, which I believed to be a placenta, was about one-half or two-thirds the size of an ordinary full-grown afterbirth. A careful examination after labor showed a somewhat hard, uneven mass in the right ovarian region, movable, gliding up under the finger into the abdomen. Peritonitis developed soon, diffuse and severe, any movement caused pain, and it was three months before she could walk about. The breasts became filled with milk, without, however, making any trouble. The breasts continued to enlarge for nearly four years, until they were enormous in size, the areola and nipple remaining black. She suffered from frequent slight attacks of peritonitis, and was most of the time unable to work. Tolerance seemed to be gradually established. The pregnancy and labor passed without any untoward symptom. The child can still be felt in the abdomen, and touched in the right ovarian region per vagina.

G.A. A very severe and protracted labor owing to a small pelvis and face presentation. Was called about 11 A.M., February 9, in the morning. Dr. Zabriskie was called in consultation; we made attempts until 7 o'clock to effect delivery by the forceps, or by turning, but the head lay so high above the brim of the pelvis that we could not make either application. About being satisfied that delivery could not, in all probability, be accomplished per vias naturalis, sent a messenger to New York after Dr. L. G. Thomas. The patient was given a dose of morphine, and at 9 o'clock Dr. Zabriskie went home, to return on the arrival of Dr. Thomas on the 2:30 train. Remaining with patient, I found her rapidly losing in strength, and at 11 her condition was very desperate, strong premonitory symptoms of eclampsia, great



Figure 4—Dr. Neer's forceps.

exhaustion, yawning, confusion of intellect, and believing she could not survive until the arrival of Dr. Thomas, and the os being well dilated, although still above the superior strait, I determined to make another effort to apply the forceps, and after some difficulty, succeeded and soon delivered her a living female child. She rallied very slowly with some incontinence of the bowels, and spasmodic pains, but finally made a good recovery.

N.S. Sixteen by this wife and 6 by his first wife.

J.S. Anencephalus [sic] child born dead before my arrival. The whole top of the head from a level of the orbit back to within 1 inch of the vertebra absent. Large well-developed child. A 22-year-old mother.

G.M. Phlebitis 1st day. Partial recovery with chill and septicemia on 8th day. Coma and death on 14th day. Husband heavy drinker. Neglected.

E.S. Called in consultation with Drs. A. D. and R. I. Bogert. Eclampsia coming on suddenly, had two or three convulsions on my arrival early in morning. Partly comatose and confused, would not take medicine, noisy at times, os size of dollar, membranes ruptured some time before, no contractions whatever. Advised them to wait and watch using chloroform freely, gave a large dose of bromides and gelsemium. Saw her again 8 o'clock. Condition same, two convulsions during my absence partly checked by chloroform. No pains, no change in os. Setting my battery in operation, passed a current through the womb from side to side causing a strong contraction with decided improvement in the os, and bringing on a severe convulsion. Waiting a short time, I applied the current again with the same results, excepting the convulsion which did not return. The pains now came on regularly every three to five minutes, with good effect, terminating the labor in the birth of a fine male child in about 3/4 of an hour. The patient during this time screaming almost constantly at the top of her voice and requiring the efforts of two or three to keep her on the bed. Dr. Bogert informed me that some hours after the convulsions returned with great violence, yielding to treatment and making a slow recovery. Urine albuminous, disappearing in a few days.

D.K. Child born with hare lip on left side, cleft extending through the maxilla, with absence of the palatine structure entirely. Operated on the seventh day on lip, producing a good lip with slight deformity. Mother says she was frightened and very much interested at seeing a man without a nose soon after her conception, to which she attributes the deformity of her child.

T.D. Patient in wretched apartments and destitution of common necessities of life. Had been in labor about 18 hours. Membranes ruptured and arm escaped about 2:30 P.M. Saw her about 10 P.M. The arm protruded to the axilla, the shoulder completely wedged in the pelvis, head and right iliac region and face posterior. After making three or four persistent efforts with my right hand to reach the feet until my arm was almost paralyzed, I was about to desist until I could procure assistance when I thought I would try the left hand, and succeeded in about 5 minutes in reaching right foot of the child and making traction while pressing the shoulder up succeeded in turning and delivering a large child that had evidently been dead for some hours. The mother made a good recovery.

J.S. Labor natural. Placenta retained for over an hour notwithstanding the uterus contracted hard and frequent pressure was made on the womb, traction, and so on without effect. Hemorrhage very slight. I remained on guard, and, as I expected, the hemorrhage came on suddenly and severely the blood flowing from the genitals, her face becoming livid in a moment, without the placenta yielding in the least. Seeing that something must be done immediately, I passed my hand into the uterus, which contracted so violently as to almost resist my efforts, and with a good deal of difficulty succeeded in tearing the placenta loose, being obliged to tear it loose with my nails to get a hold on it, and bring it away. After its removal I pushed my hand closed in the womb two or three times and allowed the uterus to expell it, which it did with great force, so as to remove all clots and secure a firm contraction. Although almost exsanguinated, she did well the first week, when being left alone, she was obliged to overexert herself and had severe chills and some metritis, which, however, passed away in a few days.

J.D. The mother was a small, delicate, nervous woman weighing 97 pounds. Labor very severe and after the head had ceased to progress for about three hours, I applied the forceps and drew it under the pubis, but did not deliver it for fear of rupturing the perineum. Left to nature, it was nearly an hour before the head passed the vulva safely, but the shoulders, which were delivered with much difficulty, produced a rent in the perineum extending nearly to the sphincter ani. The uterus seemed to be inactive for over half an hour gradually filling up with blood. A full dose of ergot had been given. Suddenly the contraction came on. The blood poured forth as from a pail, the placenta was expelled and the patient passed into a state of collapse from exhaustion and shock assisted by the profuse and sudden loss of a large amount of blood. Fortunately, she preserved her consciousness and was able to swallow. Stimulants were administered freely and friction with external warmth. Pulse

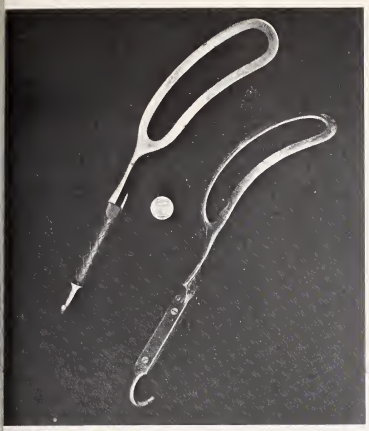


Figure 5—Dr. Neer's forceps.

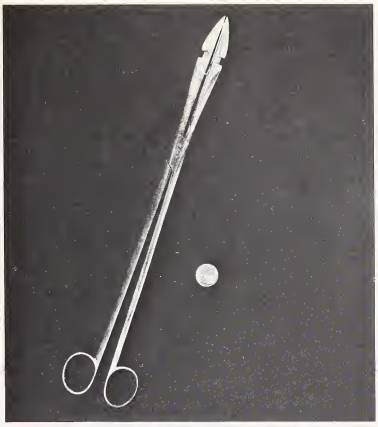


Figure 6—Dr. Neer's Smellie's scissors.

ell to 10 per minute. At the end of 20 minutes there would e 2 pulsations and a long interval, 15 to 20 per minute in a alf an hour, 3 pulsations and a rest, and it was an hour and half before the action of the heart had become regular. The mbs were kept tied together for two weeks, using a catheter, nd the perineum united perfectly. A slow but very good ecovery was made. The child weighed 12 pounds or 1/8 the eight of its mother.

A.K. Primipara. Would not believe herself pregnant. About the 8th month was called to see her in the A.M. and rrived about noon. Said she had pain in the abdomen uring night and headache. Examination revealed no sign of abor. Bowels constipated. Ordered ol. ricini and sol. romides and see. Was called again at 6 P.M. Found she had wo convulsions and another soon after my arrival. Told my river to go to Pearl River and bring Dr. Felter down. dministered seven minims of norwood's tincture veratrum iride. Gave chloroform and proceeded to make digital ilation of the cervix and by the time Dr. Felter arrived had ilated half an inch. The patient was pefectly comatose but I ad Dr. Felter administer chloroform as she began with her ifth convulsion as the Dr. came in the room. I then proceeded to rapidly dilate the cervix and when about two nches in diameter I pressed the head upward and backward vith the two first fingers of the right hand and with the left n the abdomen pressed the breech of the child downward nd backward, the membranes being still nonruptured, and uickly a version, the feet coming down to the cervix and eizing one through the membranes brought it to the vulva efore they ruptured. Delivery was soon accomplished. The hild apparently dead was resuscitated. Urine drawn with a atheter, bowels solid. Mother regained consciousness the hird day and made a good recovery. Albumen disappeared n five days. Child did well.

COMMENT

Clearly, Dr. Neer encountered and had to manage all of he problems and complications of an active and extensive obstetrical practice. It must be noted that this was all done in conjunction with an active general practice that included surgery, trauma, medicine, and pharmacy. His ingenuity, application of basic knowledge, and good judgment were astonishing and were matched by his honesty in recording good and bad results. His use of electrical stimulation of a noncontracting uterus was daring and successful. The problem of obtaining consultative help was horrendous and had to be accomplished over dirt roads by horse and carriage or by horseback. The usual consultation was with another general practitioner, yet it must have been of great comfort, if only for its reassurance. To obtain a consultant from New York City, as was done at times, involved a major endeavor of time and cooperation, and generally had no influence on the management of the case.

While his obstetrical records are interesting and varied, they are probably fairly typical of the country practice of many other physicians of that time when prenatal care was virtually nonexistent, infant mortality was high by present-day standards, but maternity mortality was reasonably low.

The courage and physical endurance of this pioneer should evoke our deep admiration. His dedication, indeed, did credit the image of the good physician who was respected, honored, and beloved by the people he served.

SUMMARY

Henry C. Neer, M.D., conducted an active, rural community medical practice from 1860 to 1911. A study of his detailed, handwritten obstetrical records of over 2,000 deliveries is interesting and instructive and gives a clear reflection of medical practice at that time. His ingenuity, application of basic knowledge, and good judgment were astonishing and were matched by his honesty in recording his good and bad results. The courage, physical endurance, and dedication of this man did much to create the image of the good physician who was respected, honored, and beloved by the people he served.

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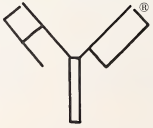
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PEDIATRIC BRIEFS

Selected Abstracts with Comments*

radsher RW: Relapse of gram-negative bacillary meningitis fter cefotaxime therapy. *JAMA* 248:1214, 1982.

In a complicated case (a 27-year-old woman with ietastatic malignancy), *Klebsiella pneumoniae* meningitis eveloped and was treated with, among other antibiotics, hree weeks of cefotaxime. She recovered but relapsed six ays later and died. The same *K. pneumoniae* organism was ound in her CSF. The cefotaxime MIC of the organism both times) was 0.06 μg/ml. "The illness in our patient uggests that further study be performed with new ephalosporins to determine the frequency of relapse in neningitis. The rate of relapse in seriously ill or im-nunocompromised patients should be assessed before the bandonment of ... proved therapeutic regime(s) ... urther clinical data regarding efficacy are required before ne third generation of cephalosporins can be given an nqualified recommendation in the therapy for gram-egative bacilliary meningitis."

urkeltaub PC, et al.: Treatment of seasonal and perennial hinitis with intranasal flunisolide. *Allergy* 37:303, 1982.

Flunisolide, a potent fluorinated corticosteroid, is safe and ffective in seasonal allergic rhinitis (as is beclomethasone, nother similar compound). Inhalation into the nose, of 20 o 200 μg per day (by adults) reduces symptoms of ragweed ayfever without suppressing the pituitary-adrenal cortical xis. A further study, double-blind and controlled, was done n 50 patients with seasonal and 75 with perennial rhinitis. The results revealed significant differences between drug and placebo in both groups. Plasma cortisol levels did not change re- and posttreatment.

Comment: Topical (nasal inhalation via spray) adminis-ration of newly synthesized potent corticosteroid congeners epeatedly has been demonstrated safe and effective in hay ever and now in perennial allergic rhinitis. This is a major dvance in the management of these occasionally severe and lways annoying conditions. Use should be most selective: or those patients whose symptoms are severe and persistent nd who readily do not respond to more traditional therapies uch as antihistamines and avoidance. I would personally refer use of these medications, under physician control and upervision, to the much more cumbersome and expensive and less effective) "desensitization." Extensive study in oung children (under age 12) has not been carried out to my knowledge.

Schwartz RH, et al.: Sulfamethoxazole prophylaxis in the titis prone child. *Arch Dis Child* 57:590, 1982.

The otitis prone child (at least three episodes of otitis nedia, OM, in one year) may represent as much as 20 ercent of the under two population. Antibiotic prophylaxis has been shown clearly to be beneficial in reducing illness frequency in such children. A double-blind crossover study (neither the patient nor the physician know whether drug or placebo initially is prescribed, and the patient is switched from drug to placebo or vice versa during the study) was undertaken to evaluate a single bedtime dose of sulfamethoxazole (25 mgm/kg). The results were gratifying. Patients who took the drug (compliance tested by urinary assay) eliminated new episodes of OM and OM with effusion occurred less frequently in the group prescribed the drug. "Sulfonamide chemoprophylaxis is effective in reducing episodes of acute OM in otitis prone young children ... during the winter when most episodes of otitis media occur, we suggest that low dose sulfafurazole or sulfamethoxazole be given once or twice daily in any young child who has has at least three episodes of acute OM within the last six months and has another infection."

Comment: Dr. Schwartz from Vienna, Virginia, and his colleagues at Children's National Medical Center, Washington, DC, have been studying otitis media and have given us much useful data. This study confirms what is known already, but reaffirms that there is an answer to the dilemma of the otitis prone child which is less invasive than myringostomy (and ? adenoidectomy). While some of you may despair of my entreaties to give up decongestants and be patient with OM with effusion, these studies permit those who are interventionist to intervene with a proved effective plan.

Mullooly JP, et al.: Impact of type A influenza on children: A retrospective study. *Am J Public Health* 72:1008, 1982.

Excess morbidity including rates of hospitalization for influenza-related conditions (pneumonia and bronchitis) occurred during an influenza A outbreak. The rate for high-risk children was six times the rate for normal children. Excess hospitalization rates for children under age 14 were three to five times greater than persons aged 15 to 65 but one-fifth that of persons over 65.

Comment: This study has proved what we intuitively would have expected. Influenza causes excess morbidity, especially

*Abstracts are from the Department of Pediatrics *Newsletter*, UMDNJ-New Jersey Medical School, Vol. 7, No. 10, 1982. Selections are made by Richard J. Rapkin, M.D., Vice Chairman and Professor, Department of Pediatrics, UMDNJ-New Jersey Medical School, and Medical Director of Children's Hospital, Newark, who is Editor; and by Coeditors, Franklin C. Behrle, M.D., Professor and Chairman, Department of Pediatrics, UMDNJ-New Jersey Medical School, and Shyan C. Sun, M.D., Associate Professor, Department of Pediatrics, UMDNJ-New Jersey Medical School, and Director of Neonatology, Children's Hospital, Newark. Correspondence may be addressed to Dr. Rapkin, Children's Hospital of New Jersey, 15 South 9 Street, Newark, NJ 07107.

in the elderly and in high-risk individuals (congenital heart disease, chronic respiratory disease, renal disease, neurological disease, and malignant disease) of any age. The risk for children significantly is greater than adults but less than the elderly. The appropriate use of influenza vaccine is encouraged and when it is clear that influenza A is around (by public health reports, especially in *Morbidity and Mortality Weekly Report),* strong consideration should be given to using amantadine or rimantadine.

Oseas RS, et al.: Usefulness of bone marrow imaging in childhood malignancies. *J Pediatr* 101:206, 1982.

Technetium^{99} sulfur colloid, the radioisotope used in liver/spleen imaging, has affinity for reticuloendothelial cells. Because of this, 5 to 10 percent of the ingested dose localizes in the bone marrow. Uptake is best in the lower extremities and varies, children 10 years and older usually have only proximal femur uptake. Bone marrow metastasis appears as focal or diffuse defects in uptake. Two hundred six bone marrow scans were done in 110 pediatric oncology patients in an effort to assess variability with age and efficacy in detecting disease. Forty of 206 studies (19 percent) were positive. Confirmation by other tests were made in each case. Four patients with active neuroblastoma had positive marrow scans with negative bone scans. (No mention was made of peripheral blood counts or instances of positive bone scans with negative marrow scans.) The conclusion was that Tc^{99} sulfur colloid was an attractive agent for qualitative evaluation of marrow function in children.

Comment: I have no problem with using bone marrow scans as an adjuvant reading when obtaining liver/spleen scans if the cost is not prohibitive, but I doubt it would replace bone scanning in a metastatic workup. As noted, skull, ribs, and forearms have poor uptake and were not evaluated in the study. Also, the lower thoracic–upper lumbar areas cannot be evaluated because of liver uptake. Marrow scans may help in certain instances of trying to differentiate osteomyelitis from infarct in sickle cell anemia. Also, there are other radioisotopes that localize in the erythroid precursor and can be of use in assessing the degree of erythropoiesis. Overall, bone marrow imaging probably has more effective use in certain hematologic situations rather than as a routine tool in oncology. (B. Ryan, M.D., Asst. Professor)

Ravitch MM: Appendicitis. *Pediatrics* 70:414, 1982.

This article represents comments by Dr. Ravitch from his own experience and the reports in the literature on the persistent percentage of occurrence of acute perforated appendicitis in most children's hospitals. Since McBurney's classic published experience with early operative interference in cases of disease of the vermiform appendix in the beginning of this century, we have, with the use of more aggressive techniques, antibiotics, appropriate fluid reconstitution, and more aggressive diagnosis, reduced the mortality of the treatment of acute appendicitis to a very acceptable level of under 1 percent. The incidence of ruptured appendicitis with peritonitis still may run from 40 to 50 percent in a children's hospital in this country and the mortality of treating ruptured appendicitis with peritonitis may be up to 7 percent.

Looking squarely at the persistent high incidence of ruptured appendicitis at the time of diagnosis, Dr. Ravitch reports in many series that the delay exists during the period of time at home before the child is brought to the attention of the physician, and also between the time of the first examination by a physician to the actual time of surgery. To improve the statistics on the treatment of acute perforated appendicitis would require that earlier diagnosis be made as well as earlier surgery once the diagnosis is presumed to be present. To be practical, with all of the various confirmatory tests that one might do, the most important item that leads a child to a surgeon and to the operating room is the physical examination with the persistent right lower quadrant tenderness, unrelenting in the history since the onset of the disease, regardless of what the laboratory shows or the x-ray show. Persistence of these findings would lead the patient to surgery with dispatch. If the delay in treatment is prolonged with the accumulation of a variety of confirmatory tests, the incidence of the rupture of acute appendicitis increases. Once peritonitis exists, the hospital stay, the treatment, the cost and the morbidity and mortality rapidly rises. It has been his observation, as it has been with us here at Children's Hospital, that if, on occasion, we remove a normal appendix because we believe that acute appendicitis is in an early stage and cannot prove otherwise, this incidence does not lead to serious morbidity. Perhaps one should better accept a few additional normal appendices removed than to accept the absolute diagnosis of acute appendicitis when it has ruptured, the child is committed to all of the complications and prolonged hospitalization for the treatment of this advanced disease.

In essence, early diagnosis and early surgical treatment still is the goal for the treatment of acute appendicitis. (A. Falla, M.D., Assoc. Professor, Pediatric Surgery)

Voora S, et al.: Fever in full-term newborns in the first four days of life. *Pediatrics* 69:40, 1982.

The authors followed 100 full-term infants who developed an axillary temperature above 37.8° during the first four days of life. The incidence of fever was 1 percent of all births. Of the febrile newborns, 10 percent had culture-proved bacterial disease. It was found, however, that most babies with a fever were not infected. Most babies (91 percent) with serious bacterial infection did indeed have a fever. Fever occurring within the first hours after birth had the least serious prognosis (of 17 infants with an early fever, 13 were delivered from mothers who had fever; 2 others had fevers caused by radiant warmers). Fevers occurring on the third day had the most chance of being associated with serious bacterial infection. Particularly ominous was the occurrence of fever associated with other symptoms compatible with bacterial disease. The authors concluded that a febrile newborn should be evaluated and treated with antibiotics when there are symptoms of infection in addition to fever or when the fever persists or recurs.

Comment: The febrile newborn always gets a great deal of attention. Often there is attention and evaluation because of the real potential for mortal infection. Therapy often is started before a diagnosis is made. Most of the time, however, infection is not found. What we learned from this article is that the lowest risk group consists of newborns with a single episode of elevated temperature and without any other clinical signs or laboratory evidence of infection. By excluding such infants, approximately one-third of febrile infants could be eliminated from invasive procedures such as lumbar punctures and bladder taps. (S. Sun, M.D., Assoc. Professor Neonatology)

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September, 1983

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Identification

DAVID I. CANAVAN, M.D., Lawrenceville*

Perhaps the most difficult aspect of the effort to deal with physicians who are the victims of impairment involves identification of the individual physician who is impaired. Two major factors are involved in creating this difficulty.

The first is massive denial on the part of the sick physician, his or her family, and their peers. Twerski defines denial as "an unconscious psychologic defense mechanism."[1] He adds, "Denial generally occurs without the person being aware of it. It is most apt to occur when the correct recognition of reality is too threatening to the person."[1] Denial is a common denominator in all of the conditions that are considered "impairment." It is important to realize that denial is not simply lying—it is an unconscious defense mechanism and the person who is into denial is unaware of the nature of this act.

It equally is important to realize that family and peers become unconsciously involved with this same defense mechanism.

The continued "social stigma" attached to these impairments creates a threat to the self-image of the physician's family members and also may carry some implied threats to their own economic security and their sense of community prestige. Denial enables them to cope with these threats.

Denial on the part of the physician's peers includes several elements. Because of the failure of our medical education system to educate physicians adequately about certain diseases, i.e. substance abuse, the physician's colleagues are often ignorant (i.e. "unknowing") in these areas and, hence, do not recognize these conditions for what they are. Moreover, the colleagues often are caught up in the "snobbery" of the profession that suggests that these conditions do not happen to successful practitioners. Finally, they are embarrassed to confront their friend, their colleague, their social companion, or their respected consultant or consultee with such an unwelcome diagnosis. Far better to find a "more acceptable" diagnosis than to risk a colleague's hostility, scorn, or rejection.

The second major factor is what is commonly referred as "the conspiracy of silence." This conspiracy is common all levels of society when it comes to dealing with patien who are the victims of substance abuse, mental illness, ar even senility.

It embodies the fear and the unwillingness on the part those who are involved closely with the victims of the diseases to blow the whistle, to speak out, and to identify th impairment and the impaired.

These close personal contacts are afraid of the hostility the patient or of possible legal recriminations; they often fe that it is none of their business; or they feel that they shou "let someone else do it." Recently I spoke to a physician wh told me he was very concerned about the alcoholic behavic of his closest physician friend, but that he could not brir himself to be the one to sound the alarm. My own reactic was: "If those who really care will not initiate the therapeut process, who will?"

Some colleagues seem to believe that ignoring the existen of these problems will help them go away. This is known a the "ostrich phenomenon." These problems will not g away! They will only get worse! Each time family, friends, professional associates fail to act, each time they excuse, each time they "cover up," they simply abet the progressic of these diseases. They become enablers.

The instinct of self-preservation plays an important ro here—as indicated by the self-protective progression of the disorders. The natural history of impairment is that it usual begins in the physician's "free time," at home, and the gradually progresses to "prime time," to the office ar finally to the public arena of the hospital and the communit If we are to reach our sick physicians, we must have help

The family usually is first to know and first to suffer th ripple effects of these diseases. The earliest problems are home and ideally should be recognized, confronted, ar

*Dr. Canavan is Medical Director, Impaired Physicians Program MSNJ. Correspondence may be addressed to Dr. Canavan, MSN. Two Princess Road, Lawrenceville, NJ 08648.

alt with there. By the time these conditions surface in the fice, the hospital, and the community, they usually are latively far advanced and already have caused considerable struction to the integrity of the family.

We must not wait until the diagnosis is so obvious that en the uneducated can make it.

All of those who are associated closely with the impaired ıysician must put aside the defense of denial. We must cast f this mantle of silence and speak out if we are to succeed.

In 1982, the AMA Council on Mental Health prepared a ɔsition statement noting: "It is the ethical responsibility of ıy physician who knows of an apparent problem in a lleague to take affirmative action—to seek treatment or habilitation for his fellow physician."[2] This responsibility ust be accepted and honored.

There are many signs that may alert the colleagues to the istence of impairment. Since the problem usually begins at ɔme, family problems often surface first. These include: creasing marital discord; adjustment problems in children the impaired; incidents of apparent "child abuse"; increas- g withdrawal from family activities; and separation or vorce.

In the professional arena many signs of impairment will rface. These include: a general decrease in self-discipline; ı indifference to responsibility; failure to follow hospital patients appropriately; changes in handwriting; deterioration of medical records; a decrease in productivity; failure to keep appointments; increasing isolation from staff functions and professional peers; increasing deterioration of personal appearance; erratic behavior; inappropriate mood swings; altercations with hospital personnel; altercations with patients; poorly explained injuries from falls while intoxicated; increased traffic accidents; arrests for driving while intoxicated; inappropriate telephone orders because of the impaired state; public intoxication at social functions; and exclusion from "local watering holes" because of antisocial behavior when drinking.

This is an extensive list and deliberately has been constructed to chart progressive impairment.

The secret of success in the treatment of impairment is early diagnosis and early intervention. We must not wait until our impaired physician has experienced all the possible consequences of these illnesses before we make the correct diagnosis and institute appropriate intervention.

REFERENCES

1. Twerski AS: *It Happens to Doctors, Too.* Hazelden, 1982, p. 25.
2. Proceedings of the 4th AMA Conference on The Impaired Physician, October 30, 1980-November 1, 1980, Baltimore, MD.

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2nd Vice-President	1 year	Edward A. Schauer, M.D., Monmouth
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5th District	3 years	John J. Pastore, M.D., Cumberland
Judicial Councilors:		
2nd District	3 years	Robert A. Weinstein, M.D., Sussex
5th District	3 years	Ronald M. Fisher, M.D., Cumberland
AMA Delegates		
	½ year	*Howard D. Slobodien, M.D., Middlesex
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	2 years	William J. D'Elia, M.D., Monmouth
	2 years	Myles C. Morrison, Jr., M.D., Morris
AMA Alternate Delegates		
	1½ years	Daniel J. O'Regan, M.D., Hudson
	2 years	Edward A. Schauer, M.D., Monmouth
	2 years	Augustus L. Baker, Jr., M.D., Morris
	2 years	James H. Spillane, M.D., Warren
	2 years	Frank Y. Watson, M.D., Essex

*If elected, vacancy will occur for unexpired term May, 1983, to December, 1983, as AMA Alternate Delegate. The ½-year term is being utilized to allow staggered tenure among the Delegation.

Office	Term	Nominee and County
Delegates and Alternate Delegates to Other States:		
New York:		
Delegate	1 year	F. Sterling Brown, M.D., Atlantic
Alternate	1 year	John J. Pastore, M.D., Cumberland
Connecticut:		
Delegate	1 year	Frank R. Romano, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
Administrative Councils:		
Legislation:		
1st District	3 years	Anthony P. Caggiano, Jr., M.D., Essex
4th District	3 years	Irving P. Ratner, M.D., Burlington
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1st District	3 years	Richard H. Sharrett, M.D., Union
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Mental Health:		
1st District	3 years	Alvin Friedland, M.D., Essex
2nd District	3 years	William H. Bristow, Jr., M.D., Bergen
Public Health:		
6th Member	1 year	Glenn P. Lambert, M.D., Hunterdon
1st District	3 years	Edward M. Coe, M.D., Union
4th District	3 years	William Pawluk, M.D., Burlington
Public Relations:		
1st District	3 years	Robert J. Lorello, M.D., Essex
4th District	3 years	Jesse Schulman, M.D., Ocean
Standing Committees:		
Annual Meeting	3 years	John F. Marshall, M.D., Mercer
Auxiliary Advisory	3 years	George T. Hare, M.D., Camden
Finance and Budget	3 years	B. Ralph Wayman, Jr., M.D., Mercer
Medical Defense & Insurance	3 years	Carl A. Restivo, Jr., M.D., Hudson
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Trustees' Minutes February 13, 1983

A regular meeting of the Board of Trustees was held on Sunday, February 13, 1983, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Report of the President . . .

(1) Reconsideration of S-488 and A-1087—Appointment of a Limited Guardian for Certain Persons Exposed to Coercive Persuasion . . . Decided to rescind its former position and approve **S-488** and **A-1087;** in the event that this legislation represents an unconstitutional means, then some other way should be found to fulfill the objective.

Report of the Executive Director . . .

(1) MSNJ Paid Membership . . . Noted that as of January 31, 1983, 4,315 members have paid their MSNJ dues for 1983; this figure compares favorably with the 1982 figure.

(2) Letter to Insurance Department Concerning Blue Shield . . . Approved for submission a letter to the Commissioner of Insurance protesting the discrimination against nonparticipating physicians under the PACE program.

(3) Legal Matters . . .

(a) State Board of Medical Examiners vs. Strauch; vs. Aluri . . . Noted that the motion to appear amicus in the Appellate Division has been opposed by the State Board of Medical Examiners (SBME). Noted that in these actions the decision of the administrative law judge was overruled by the SBME and the physicians were disciplined by the State Board of Medical Examiners.

(b) Subordinated Loan Deductibility . . . Noted that the case is moving close to trial in the Tax Court, possibly by the beginning of March.

(c) Physical Therapy Services . . . Noted that there still are areas of concern with **A-2057** that would establish physical therapy as a free-standing health profession with its own regulatory board, and an attempt will be made to include amendments to this bill.

(4) MSNJ Financial Statements . . . Reviewed and approved the January 31, 1983, financial statements.

(5) Annual Meeting Session Attendance Cards . . . Agreed to discontinue the use of annual meeting session attendance cards.

(6) Academy of Family Physicians Program on Aging . . . Approved a request to provide the Society's facilities for a program on the problems of the aging population and to cosponsor the program with the Academy of Family Physicians.

(7) HRET Telecommunications Network . . . Approved MSNJ's participation in the Health Research and Educational Trust of New Jersey Telecommunications Network and authorized the expenditure of $25,000.

University of Medicine and Dentistry of New Jersey . . .

(1) Tuition Increase . . . Noted that if UMDNJ increases its tuition, it would become the most expensive public medical school in the nation. Noted that currently UMDNJ is the third most expensive public school.

(2) University Hospital . . . Noted that the UMDNJ Board of Trustees signed a management contract with Hospital Corporation of America. Noted the UMDNJ Board of Trustees established a committee on corporate restructuring of University Hospital.

(3) Fifth Channel Program . . . Noted that the Fifth Channel Program will be eliminated when the class currently applying for admission completes its year of study. Noted that UMDNJ will consider continuing a limited version of the program if there is a future need.

(4) Commencement . . . Noted that the theme of this year's commencement (May 25, 1983) is health promotion and disease prevention. Noted that Doctor Jean Mayer will deliver the commencement address and UMDNJ will bestow honorary degrees upon Doctor Mayer and Doctor Lena Edwards-Madison.

Council on Mental Health . . . Approved the following recommendation:

That the Department of Human Services be urged to continue the county medical health boards as separate entities, and not subordinate to planning councils.

Council on Public Health . . .

(1) Freeze and Reduction of Nuclear Weapons . . . Approved the following resolution:

Whereas, the greatest challenge facing the earth is to prevent the occurrence of nuclear war by accident or design; and
Whereas, the nuclear arms race dangerously is increasing the risk of a holocaust; and
Whereas, reductions in nuclear warheads, missiles, and other delivery systems are needed to halt the nuclear arms race and to reduce the risk of nuclear war; now therefore be it
Resolved, that all countries should pursue major, mutual, and verifiable reductions in nuclear weapons with the objective to final elimination of all nuclear weapons.

(2) Burlington County Medical Society—Toxic Waste Burning . . . Approved the following recommendations:

(1) That the Medical Society of New Jersey take no position on the trial operation of Trofe Incineration, Inc., for toxic waste burning as authorized by the New Jersey Department of Environmental Protection. (This report is not intended to constitute an endorsement of the operation of the facility as a toxic waste incineration site. It is unfortunate that the site for these test burns is in a highly populated area.)
(2) That the state of New Jersey be urged to consider population when approving the location of any future test sites.

(3) Union County Medical Society—Distribution of Antituberculosis Medication . . . Approved the following recommendation:

That the Medical Society of New Jersey advise the Commissioner of Health, the Governor of New Jersey, and the appropriate legislators that it is hoped the state will continue to provide adequate means to continue to control tuberculosis in New Jersey.

(4) American Cancer Society's Colorectal Screening Program . . . Referred the American Cancer Society's proposed colorectal screening program back to the Council on Public Health for review and report.

Note: Concerns with the proposed forms to be used in the program and reservations about the procedures to be followed for this program were discussed. The Board agreed that all issues should be resolved before the program is approved.

Committee on Drug and Alcohol Abuse . . .

(1) **Evaluation of Prescription Practices in Conjunction with the Drug Enforcement Agency (DEA) . . .** The following amended recommendation was approved:

That the Board approve the concept of the Committee on Drug and Alcohol Abuse assisting the DEA in the medical evaluation of unusual prescribing of controlled dangerous substances. *This is to be done under complete immunity.* (Italics denotes deletion by the Board.)

(2) **State Board Committee on Illegal Division of Drugs . . .** Approved the following recommendation:

That MSNJ request the State Board of Medical Examiners to add representation from the Medical Society of New Jersey, the Department of Health, New Jersey Association of Osteopathic Physicians and Surgeons, New Jersey Dental Association, New Jersey Pharmaceutical Association, and the Pharmaceutical Manufacturers Association to the committee on illegal diversion of drugs, proposed to the State Board of Medical Examiners at their December 8, 1982, meeting.

Joint Meeting of the Standing Committee on Revision of Constitution and Bylaws and the Special Committee on Long-Range Planning and Development...

(1) **Parameters for Absenteeism at Board Meetings . . .** Approved the following amended recommendation:

That the Board adopt a policy that any trustee absent from four meetings in any administrative year *may* be removed for "good cause." (Italics indicates amendment by the Board.)

(2) **Proposed Amendments to the Bylaws . . .**

(a) **Specialty Society Representation . . .** Will submit a report to the Reference Committee on Constitution and Bylaws commenting on the bylaw amendment concerned with specialty society representation in the House of Delegates.

Note: Comments were made concerning the duplication of specialty societies on the proposed list and noted that the proposed list should include only those specialties that have complied with the criteria set forth in the bylaw amendment.

Old Business . . .

New Jersey Medicaid Competition Demonstration Project—Medicaid Family Health Plan . . . Authorized MSNJ's participation in the New Jersey Medicaid Competition Demonstration Project.

New Business . . .

(1) **AMA Delegate Allocation for 1983 . . .** Notified that New Jersey will increase its number of AMA delegates to nine and noted that open nominations from the floor will be considered by the House of Delegates for the new positions.

(2) **Committee on Medicine and Religion . . .** Discharged the Committee on Medicine and Religion and assigned its scope of activity to the newly created Committee on Biomedical Ethics.

(3) **Announcement of a New Commissioner of Health . . .** Sent a letter of congratulations to J. Richard Goldstein, M.D., the new Commissioner of Health.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

Advanced technology, shortened to "high tech" in the popular idiom, dominates much of our talk and our thinking. "High tech," describing everything from a computer chip to the million-dollar linear accelerator at our soon-to-open Cancer Research and Treatment Center, Newark, neither will provide a job for every laid-off auto worker nor guarantee a long life to every cancer victim. But advanced technology does offer real hope of future employment for hundreds of thousands of present-day students and workers and the prospect of better health at lower expense for many of us.

We can create our own corridor of opportunity in high technology by building on our current strengths as one of the nation's foremost research centers. If New Jersey makes the substantial commitment required to transform our state into an educationally and professionally fertile area for "high tech," we can realize significant economic and employment benefits.

That is why, as President of the University of Medicine and Dentistry of New Jersey and Chairman of the Board of Trustees of the New Jersey Association of Colleges and Universities, I recently testified before the Assembly Committee on Higher Education and Related Professions in support of A-2093. Sponsored by Assemblyman Joseph Doria, this bill would provide a $75 million bond fund for the purchase and renovation of research equipment at public universities and colleges. Educating people for high technology, which is the special challenge of higher education, requires the best facilities as well as the best educators.

In the health field, "high tech" means biotechnology, which ranges from the development of sophisticated diagnostic equipment to devices designed to enhance the human skeletal and muscular systems.

UMDNJ is increasingly active in this area and undoubtedly will do more with the infusion of public and private dollars generated by the proposed bond issue. By fostering collaborative relationships between university researchers and private corporations, we increase the likelihood that products of biochemical engineering will be made here by New Jerseyans we have educated for the "high tech" future.

UMDNJ is not waiting for legislators and voters to approve the bond issue. The university already has persuaded an internationally known scientist to bring his cancer research program and a related high technology corporation to our Newark campus.

David M. Goldenberg, Sc.D., M.D., professor of pathology at the University of Kentucky and director of the Division of Experimental Pathology at the University of Kentucky Medical Center, has signed a letter of intent with UMDNJ to form a Center for Molecular Medicine and Immunology to advance his pioneering work in cancer radioimmunodetection. An experimental technique, radioimmunodetection uses antibodies to detect, diagnose, and treat human cancer.

Dr. Goldenberg's corporation, Immunomedics, will produce health care products related to his cancer research efforts. He has been negotiating a corporate development relationship with pharmaceutical manufacturers.

With this agreement, New Jersey gains a research center on the leading edge of biotechnological research and a precedent for attracting other "high tech" activity. Besides the enormous potential for cancer diagnosis and therapy, Dr. Goldenberg's team will enhance university patient care programs and provide unique educational opportunities for our students.

Dr. Goldenberg was one of the first scientists to demonstrate that antibodies produced in animals could be labeled with a radioactive marker, injected into humans, and bonded to cancer cells to reveal tumor sites with high precision. He and his group report a 90 percent success rate in identifying tumors in 51 patients with intestinal cancers. In 11

ases, the tumors had gone unidentified
y conventional tests.

The Goldenberg group is experiment-
ng with a technique using antibodies to
irry drugs or radiation that will destroy
ancerous cells without harming healthy
ssues. Their work with monoclonal
ntibodies may be a clue to the diagnosis
nd treatment of AIDS (acquired im-
une deficiency syndrome), a new,
preading, and often fatal disorder for
hich no cure is now known.

Dr. Goldenberg will bring a team of
x researchers from Kentucky to com-
rise the core of the research center,
hich will open with more than $1 mil-
on in research grants. Each scientist
ill become a nontenured, unsalaried
niversity faculty member and will teach
tudents and contribute to health care
elivery on the Newark campus, particu-
rly in chemotherapy and radiotherapy
or cancer patients.

The Center for Molecular Medicine
nd Immunology will provide outpatient
are for cancer diagnosis and treatment
sing radioimmunodetection. The meth-
dologies and resources of the Center
ill have treatment applications in
ardiology, neurology, gastroen-
erology, nephrology, gynecology, and
ther disciplines.

We see this as a most important and
xciting step forward for medicine in
New Jersey.

MSNJ Auxiliary

Linda B. Hirsch
President

At the Winter MSNJ Auxiliary Executive Board meeting, approval was given for the establishment of a Committee on Impaired Spouses of Physicians. The Chairman of this Committee, Mrs. Josephine Pesaresi (Bergen County), also serves on the Medical Society of New Jersey Committee on Impaired Physicians. All inquiries to Mrs. Pesaresi will be confidential. David I. Canavan, M.D., Medical Director of the Medical Society of New Jersey Impaired Physicians Program, will serve as advisor in directing appropriate procedures. It is important that MSNJ Auxiliary provide services to auxiliary members who are impaired. Our goal is to improve the quality of life of everyone, and we should begin with ourselves.

Issues of particular concern discussed at the Board meeting included the Auxiliary's active participation in county programs on dangers of drinking and driving; mandatory seat belts on school buses was seen as an important project for county auxiliaries to pursue.

This is the first year of MSNJ Auxiliary's collaboration with the American Cancer Society, New Jersey Division. Auxiliary liaison, Mrs. LaVerne Fioretti, distributed brochures for physicians' offices regarding cancer detection. County auxiliaries were urged to contact the American Cancer Society county offices for direction regarding appropriate activities and programs for education concerning cancer.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Robert M. Klein, M.D., 5959 Delafield Ave., Riverdale, NY 10471. New York Medical College 1976. Subspecialty, pediatrics. Board certified, pediatrics; board eligible, immunology/allergy. Single or multispecialty group, partnership, solo, institutional. Available July 1984.

ANESTHESIOLOGY—Bert Guajardo, M.D., 7907 Belle Park Dr., Houston, TX 77072. Creighton 1979. Board eligible. Group or partnership. Available.

FAMILY MEDICINE—David Kaufman, M.D., 70 Lancaster Rd., West Hartford, CT 06119. St. Louis 1975. Board certified. Partnership or group. Available July 1983.

Max Burger, M.D., 11 West 69th St., New York, NY 10023. Royal College of Surgeons (Ireland) 1976. Board certified. Group, HMO, partnership. Available.

William J. Rayner, M.D., 616A Country Club Parkway, Mt. Laurel, NJ 08054. New York Medical College 1975. Board certified. Group. Available July 1983.

GASTROENTEROLOGY—William W. Mark, Jr., M.D., 2289 South Lewiston St., Aurora, CO 80013. Guadalajara (Mexico) 1975. Also, general internal medicine. Group or partnership. Available June 1983.

Leonard Luterman, M.D., 5740 Cavendish Blvd., Apt. 1308, Montreal, Quebec, Canada H4W 2T8. McGill 1977. Also, general internal medicine. Board eligible. Any type practice. Available July 1983.

Louis D. May, M.D., 2122 Kensington Ave., Salt Lake City, UT 84108. Miami 1978. Also, general internal medicine. Board certified (IM). Group or partnership. Available June 1983.

Satya V. Jayanty, M.D., 131 Breckinridge Square, Louisville, KY 40220. Andhra (India) 1974. Also, general internal medicine. Board certified (IM). Partnership. Available July 1983.

N.P. Narayana, M.D., 31 Minebrook Rd., Apt. 169-B, Edison, NJ 08820. Mysore (India) 1971. Also, general internal medicine. Board certified (IM). Partnership, solo, group. Available July 1983.

Joseph S. Tan, M.D., 3221 Bloomfield Lane, #505, Auburn Heights, MI 48057. University of Santo Tomas (Philippines) 1975. Also, internal medicine. Board certified (IM). Partnership, group, solo. Available July 1983.

GENERAL PRACTICE—Alan D. Brownfield Palo, M.D., 6611 Pelham Dr., Parma, OH 44129. Guadalajara (Mexico) 1976. Special interest in ENT. Office-based general ENT, surgical ER, surgical house staff. Available.

Jayen C. Shah, M.D., 4848 North Kimball, Apt. 2-N, Chicago, IL 60625. Baroda (India) 1974. Also, emergency room medicine. Group, partnership, solo. Available.

Mustafa Boyer, M.D., 168 S. Kentucky Ave., Atlantic City, NJ 08401. Istanbul (Turkey) 1943. Partnership, nursing home, hospital house physician. Available.

INTERNAL MEDICINE—William W. Mark, Jr., M.D., 2289 South Lewiston St., Aurora, CO 80013. Guadalajara (Mexico) 1975. Subspecialty, gastroenterology. Group or partnership. Available June 1983.

David George, M.D., 76 St. Paul St., Apt. 6, Brookline, MA 02146. Harvard 1978. Subspecialty, rheumatology. Board certified. Group. Available July 1983.

Arthur C. Tutela, M.D., 132 Midland Place, Newark, NJ 07106. Bologna (Italy) 1974. Also, general medicine. Group, partnership, clinic, institution. Available.

Andrew Stolzar, M.D., 3 Petunia Drive, Apt. 2-C, North Brunswick, NJ 08902. Graz (Austria) 1979. Board eligible. Group or partnership. Available July 1983.

Richard M. Moccia, M.D., 10 Loden Lane, Rochester, NY 14620. Dartmouth 1977. Also, gastroenterology. Board certified (IM); board eligible (gastroenterology). Solo, group, partnership, hospital-based practice combining IM and consultative GI. Available June 1983.

Dennis Parenti, M.D., 131-F Marina Drive, Edison, NJ 08817. Washington University 1978. Subspecialty, rheumatology. Board certified (IM); board eligible (rheumatology). Partnership or group. Available July 1983.

Robert M. Lintz, M.D., 80 High St., Apt. 21-B, Dedham, MA. Jefferson 1978. Subspecialty, gastroenterology. Board certified. Group, partnership, solo. Available.

Stewart A. Robbins, M.D., 73-11 210th St., Apt. 2-K, Bayside, NY 11364. SUNY-

Downstate 1978. Subspecialty, gastroenterology. Board certified. Group, or partnership. Available July 1983.

Mel Kaplan, M.D., 48 Medinah Dr., Reading, PA 19607. New York University 1976. Board certified. Any type practice. Available.

Viswanath P. Vasudevan, M.D., 59-21 Calloway St., Apt. 5-L, Corona, NY 11368. Bombay (India) 1976. Subspecialty, pulmonary medicine. Board certified. Group or solo. Available July 1983.

Khalid I. Khan, M.D., 3317 Old Church Rd., Augusta, GA 30907. Khyber (Pakistan) 1975. Subspecialty, pulmonary medicine. Board eligible. Group or partnership. Available July 1983.

N.P. Narayana, M.D., 31 Minebrook Rd., Apt. 169-B, Edison, NJ 08820. Mysore (India) 1971. Also, general internal medicine. Board certified (IM). Partnership, solo, group. Available July 1983.

Joseph S. Tan, M.D., 3221 Bloomfield Lane, #505, Auburn Heights, MI 48057. University of Santo Tomas (Philippines) 1975. Also, gastroenterology. Board certified. Partnership, group, solo. Available July 1983.

Martin Estok, M.D., 50 Wilson Ave., Newark, NJ 07105. UMDNJ 1980. Board eligible. Group, partnership, solo. Available July 1983.

David Bleeker, M.D., 200 Carman Ave., Apt. 1-C, East Meadow, NY 11554. SUNY-Downstate 1980. Board eligible. Group or partnership. Available July 1983.

NEPHROLOGY—Carl S. Goldstein, M.D., 860 Gates Pavilion, 3400 Spruce St., Philadelphia, PA 19104. Washington University 1978. Also, general internal medicine. Board certified (IM). Group or partnership. Available July 1983.

OBSTETRICS/GYNECOLOGY—Francine A. Guzman, M.D., 132-17 58th Rd., Flushing, NY 11355. New York Medical 1979. Board eligible. Group or partnership. Available June 1983.

Ho Young Kim, M.D., 1945 Corlies Ave., Neptune, NJ 07753. Chonnam (Korea) 1972. Board eligible. Solo, group, partnership. Available July 1983.

OPHTHALMOLOGY—Michael Hostovsky, M.D., 4100 West 36th St., Minneapolis, MN 55416. Hadassah (Israel) 1972. Also, neuro-ophthalmology. Board eligible. Single or multispecialty group. Available.

Jasvinder Singh, M.D., 500 Central Ave., Apt. 702, Union City, NJ 07087. Lady Hardinge (India) 1970. Board eligible. Partnership, group, HMO. Available.

OTOLARYNGOLOGY—Richard Schiffman, M.D., 2717 East 28th St., Brooklyn, NY 11235. Tufts 1977. Board eligible. Partnership or group. Available.

Kwang H. Choi, M.D., 8704 Pellington Place, Apt. 3, Richmond, VA 23229. Seoul (Korea) 1976. Board eligible. Partnership or associates. Available July 1983.

Bruce Grossman, M.D., 215 East Chicago Ave., Apt. 1101, Chicago, IL 60611. Illinois 1978. Board eligible. Group or partnership. Available July 1983.

PATHOLOGY—Siamak Shokri-Tabibzadeh, M.D., Montefiore Hospital and Medical Center, 111 E. 210th St., Bronx, NY 10467. Tehran (Iran) 1977. Academic institution. Available.

Marvin N. Solomon, M.D., 3 Sutliff Ave., Vineland, NJ 08360. Berne (Switzerland) 1937. Special interest in anatomic and forensic. Board certified (PA); board eligible (forensic). Hospital staff, locum tenens. Available.

Pushpa Gupta, M.D., 100-C Thorndale Dr., Dayton, OH 45429. Dr. S.N. Medical College (India) 1971. Any type practice. Available.

PEDIATRICS—Shailesh J. Shah, M.D., 430 E. 67th St., Apt. 5-C, New York, NY 10021. Baroda (India) 1974. Board eligible. Special interest in pediatric hematology/oncology. Group, partnership, institutional. Available July 1983.

Renuka D. Desai, M.D., 1258 Liberty Bell Dr., Cherry Hill, NJ 08003. GS Medical College (India) 1973. Board certified.

217th Annual Meeting
April 29–May 2, 1983

Resorts International
Atlantic City, New Jersey

Daily Schedule

Friday, April 29, 1983
3:30 p.m.—Board of Trustees' Meeting
5:00 p.m.—Delegate Registration
7:00 p.m.—Officers' Cocktail Reception followed by Dinner

Saturday, April 30, 1983
7:30 a.m.—Delegate Registration
9:00 a.m.—House of Delegates
9:00 a.m.—Message Center, Scientific, Informational, and Insurance Exhibits Open
10:30 a.m.—House of Delegates (election)
12:00 noon—Golden Merit Award Ceremony followed by Reception
1:00 p.m.—Reference Committee Meetings
5:00 p.m.—JEMPAC Political Forum
5:45 p.m.—JEMPAC Wine and Cheese Reception

Sunday, May 1, 1983
8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—Scientific Sessions
12:00 noon—Luncheons
1:00 p.m.—Scientific Sessions
6:30 p.m.—Inaugural Reception followed by Inaugural Dinner

Monday, May 2, 1983
6:30 a.m.—County Society Breakfast Caucuses
8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—House of Delegates
12:00 noon—Message Center, Scientific, Informational, and Insurance Exhibits Close
12:00 noon—House Adjourns for Lunch
1:30 p.m.—House Reconvenes
3:00 p.m.—Board of Trustees' Meeting

roup or partnership. Available.

nn M. Hawryluk, M.D., 1804 Windsor idge Dr., Westborough, MA 01581. larvard 1980. Board eligible. Group, partership, HMO, solo. Available July 1983.

dgar C. Orate, M.D., 1945 Corlies Ave., eptune, NJ 07753. University of the East Philippines) 1978. Board eligible. Group, artnership, solo. Available July 1983.

lan M. Muney, M.D., 2353 Moreno Dr., os Angeles, CA 90039. Brown 1978. loard eligible. Group or partnership. vailable.

YCHIATRY—Paul L. Maitheny, M.D., 9 Pawnee Rd., Lakewood, NJ 08701. Uniersity of Graz (Austria) 1951. Board ligible. Available.

LMONARY DISEASES—Young J. Ko, M.D., 2927 Dorchester St., Apt. 206, Troy, MI 48084. Chonnam (Korea) 1973. Also, eneral internal medicine. Board certified IM); board eligible (PM). Solo, group, artnership. Available July 1983.

M. Zaslow, M.D., 24 Westgate Rd., Chestnut Hill, MA 02167. Harvard 1977. Also, general internal medicine. Board ertified (IM); board eligible (PM). Any ype practice. Available.

ADIOLOGY (DIAGNOSTIC)—Kailash Tarneja, M.D., 8710-A Park Crestwood Dr., Crestwood, MO 63126. Delhi (India) 1974. Board eligible. Group, partnership, solo. Available.

Michael M. Abiri, M.D., 1077 River Rd., Edgewater, NJ 07020. Tehran (Iran) 1972. Board certified. Any type practice. Available.

HEUMATOLOGY—David George, M.D., 76 St. Paul St., Apt. 6, Brookline, MA 02146. Harvard 1978. Also, general internal medicine. Board certified (IM). Group. Available July 1983.

URGERY, GENERAL—James P. Gadzik, M.D., 414 Country Lane, Narberth, PA 19072. Pennsylvania 1976. Group, partnership, general surgery (with vascular and thoracic). Available July 1983.

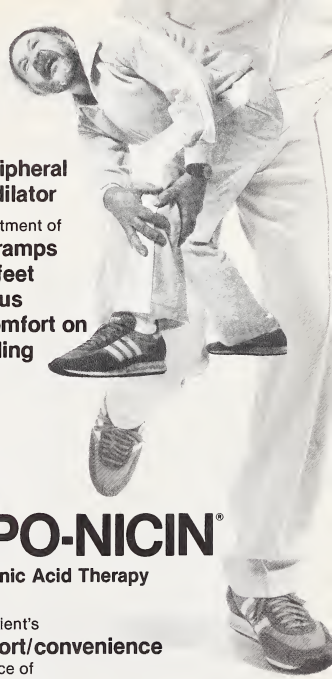
URGERY, ORTHOPEDIC—Shearwood J. McClelland, M.D., 380 E. Town St., Columbus, OH 43215. Columbia 1974. Board certified. Partnership or group. Available.

URGERY, THORACIC—John P. Hubert, Jr., M.D., 33 Viking Village, N.W., Rochester, MN 55901. Minnesota 1975. Board certified. Private practice, single specialty in small group. Available July 1983.

URGERY, VASCULAR—John P. Hubert, Jr., M.D., 33 Viking Village, N.W., Rochester, MN 55901. Minnesota 1975. Board certified. Private practice, single specialty in small group. Available July 1983.

ROLOGY—V.P. Nagarajan, M.D., 61 Maple Ct., Apt. 4, Snyder, NY 14226. Tirunelvel (India) 1973. Solo, group, partnership. Available July 1983.

Marc Nierman, M.D., 14 Jennings Rd., Waltham, MD 02154. Wisconsin 1978. Board eligible. Group or partnership. Available July 1983.



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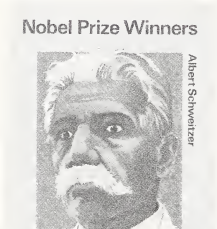
MEDICAL PHILATELY

Missionary Medicine

JOSEPH H. KLER, M.D., New Brunswick

When Dr. Albert Schweitzer (1875-1965) was awarded the Nobel Peace Prize in 1953, congratulatory messages streamed to Lambaréné from kings, presidents, ministers of state, scholars, old friends, and people from all walks of life representing all nations in the world.

Dr. Schweitzer used the prize money to continue further construction in Lambaréné, particularly facilities to treat lepers with newly discovered effective drugs. These drugs were developed by American scientists and Dr. Schweitzer's American friends supplied these drugs to him. Dr. Schweitzer was among the very first in the world to use these effective drugs.



Schweitzer
Saint Lucia, 1980

Dr. Schweitzer became a master in three separate disciplines: music, theology, and missionary medicine. He was considered the most accomplished organist of his day.

Dr. Albert Schweitzer passed away quietly, in peace and dignity, at 11:30 P.M. on September 4, 1965, of bronchial pneumonia and myocardial insufficiency. Few physicians have faced the variety of persistent health problems that he encountered when he arrived in the jungle in 1913. Fewer still ever have labored as hard and as many hours each day as Dr. Schweitzer did for 52 years.

Dr. Schweitzer established a hospital for African people. He was successful in introducing good surgical and public health measures to control the ailments and tropical diseases of the native people. His efforts on behalf of the African people earned him the 1952 Nobel Prize for Peace.

Dr. Schweitzer's daughter, Mme. Rhena Eckartas, the new administrator, and Dr. Walter Munz, the new physician of the Lambaréné hospital and clinic modernized the facilities but the hospita continued to be "an African village where people can come with families goats, and chickens to continue thei village life even when under treatment,' as Dr. Schweitzer wished.



Schweitzer and Organ Pipes
Upper Volta, 1967

LETTERS TO THE EDITOR

New Jersey's Fifth Pathway

January 17, 1983

Dear Dr. Krosnick:

This letter is in reference to the article, "New Jersey's Fifth Pathway: The Returns for the Effort," by Gordon French, M.D., and Joan Semen which appeared in the November, 1982, issue of *The Journal*. The article cites the performance of medical graduates from the Universidad Autonoma de Guadalajara in the American Board of Internal Medicine (ABIM) certifying examinations to support their assumption that "foreign trained [medical] students, as a whole, represent a permanent defect in quality."[1] The 18 percent pass rate of these students was compared to the 89 percent pass rate of American medical school graduates and was viewed as an implication of "not only a corresponding gap in relevant knowledge, but also an inability to acquire such knowledge. This is sobering evidence that the postgraduate learning capacity of this group radically is less than of graduates of United States medical schools and that only a minority of them will become accredited in a major specialty. Training cannot account for this great defect nor can it remedy it." To support these statements, the authors refer to two studies that were neither cited in their bibliography nor traceable in the English literature. I, therefore, question the validity of their conclusions.

Furthermore, the report deals with a group of foreign medical graduates (FMGs) who, at the time of their admission to the Fifth Pathway Program, never had any supervised clinical clerkships in the United States and whose responsibilities as Fifth Channel students were nothing more than that of observers with very little "hands-on" experience. In other words, the "supervised clinical training" that they received was nothing but a form of apprenticeship, the type of education which has been abandoned by American medical schools since the early part of this century. From my personal communications with Fifth Pathway students and from the literature, there seems to be a marked difference at least between the quality of medical education provided by the New Jersey and the New York Fifth Pathway Program.[3-5] It seems worthwhile to find out if there is a difference in the performance of their respective graduates before making hasty conclusions.

Lastly, I think it is remarkable that some of these FMGs achieved an academic level comparable to graduates of American medical schools in spite of their educational handicaps. It must be pointed out that although only 18 percent have attained Board certification, none of the candidates should have been allowed to sit for the examination unless he or she was adjudged by the Program Director to possess the essential medical knowledge and clinical skills.[6] In fact, 89 percent of those reported in this article have passed the medical licensure examinations either in New Jersey or in other states.

In absolute terms, 718 American medical school graduates failed the 1980 ABIM certifying examinations on the first try compared to 133 United States FMGs.[2] If we are to accept the passage of a certifying examination as the sole measure of a physician's clinical competence, a lot more American medical school graduates than FMGs would fall below Dr. French's standards. In these times when medical schools are reassessing their admission policies and criteria,[7] I caution the authors to think twice before labeling a foreign medical student "inferior" or a "reject."

(signed) Elpidio C. Mariano, M.D.

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1. French GN, Semen JR: New Jersey's fifth pathway: The returns for the effort. *J Med Soc NJ* 79:903-906, 1982.
2. Benson JA, Meskauskas JA, Grosso LJ: Performance of U.S. citizen—foreign medical graduates on certifying examination in internal medical. *Am J Med* 71:270-273, 1981.
3. McGough WE: Fifth pathway in New Jersey. House officer preparatory course for U.S. foreign medical graduates. *JAMA* 232:1031-1033, 1975.
4. Rosner F, Mulvihill JE: American foreign medical graduates' performance after a year of supervised clinical clerkships (fifth pathway). *JAMA* 241:714-716, 1979.
5. Mulvihill JE, Rosner F: Americans studying medicine abroad. Six years' experience with supervised clinical year of training ("fifth pathway"). *NY State J Med* 79:744-780, 1979.
6. Webster GD: Assessment of clinical competence by certification. *J Med Soc NJ* 75:675-677, 1978.
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Physicians and Adoptees

December 16, 1982

Dear Dr. Krosnick:

Although hard figures are difficult to come by, a conservative estimate of the number of adoptees in the United States today is about five million people. When nuclear families of those adoptees are taken into account as representing people directly involved with adoption, that number goes up to about 12 percent of the nation's population. Using either figure, a significant amount of people are represented. It, therefore, would seem appropriate for the medical profession to address this segment of the population in some meaningful fashion.

Contrary to popular notions regarding adoption, typical adoptions today frequently involve school-age children and/or those with some form of handicap, including emotional ones. Due to this fact, an adoptive family might have more contact with those in the medical field than other families. Consequently, what is needed from the medical practitioner is sensitivity in dealing with these families.

Infrequent though it may be, as an adoptive parent and one who works in the area of child welfare, I have had the unpleasant experience, as have others, of

coming in contact with doctors who were judgmental of the decision to adopt. This appears to be especially true when the adopted child is handicapped. These are the very children and families that need the extra support of the physician, not disapproval.

Doctors should be the guiding force in assisting a family to get the proper diagnostic testing for their child resulting in the most appropriate treatment program based on the conditions found to be present. Unfortunately, this is not always the case and referrals are not made.

The adoptive home provides the love and stability the child needs but must rely on the expertise of those it contacts in the medical profession to deal with whatever handicaps the child may have. If that expertise is not shared, the potential of the child will not be maximized in spite of all of the love, hard work, and good intentions of the adoptive parents.

More and more of the adoptions of special needs children are being subsidized. This still is more cost effective than maintaining these same children in long-term foster care or institutional living arrangements. The subsidy often provides medical coverage for the child. As doctors refuse to accept Medicaid patients, the options for medical care for these children decreases.

It is hoped that a greater awareness of the needs of adoptive families coupled with an increase in support to them from the medical profession will make parenting the adopted child, particularly those with handicaps, a little easier.

(signed) Deborah Lorenzette
Spaulding for Children

Explaining the Paradoxical Effect of Stimulants for Hyperactivity to Parents

January 26, 1983

Dear Dr. Krosnick

The letter by Lutz and Lutz (March, 1982) shows once again how astute clinicians can make very perceptive observations that have the ring of truth. However, it may be possible to confirm the clinical data reported in their letter in scientifically acceptable ways. It certainly is reasonable to believe that if a child benefits from a stimulating drug his brain probably is underaroused, just as the catatonic schizophrenic who improves on intravenous amobarbital sodium probably is overaroused. Subjects who are underaroused tend to show slow rhythms in the EEG while those who are overaroused show fast rhythms.

If one tells the parents of hyperactive children that the adrenergic stimulants prescribed for them increase cerebral arousal and thus enable the brain to function in a more mature fashion this is, as Lutz and Lutz say, plausible and usually readily accepted. I would suggest that the authors organize their data so that they can tell us what proportion of patients with slow EEGs responded and what did not; and also, if they gave stimulants to patients with normal or fast brain waves, what proportion did or did not respond. I would expect the results to confirm their clinical impression; it may be that the group who do not benefit from stimulants are in fact those who are not underaroused, and the authors might add significantly to our ability to prescribe effective treatment if they analyzed their data in this simple way.

Can the authors (or other of your readers) provide information on the EEGs of grownup hyperactive children, i.e. attention deficit disorder, residual type in adults? These sometimes respond to stimulants but rarely as predictably as in children.

(signed) A. Arthur Sugerman, M.D.

PDR Disclaimer

January 21, 1983

Dear Doctor Krosnick:

The Physicians' Desk Reference no doubt is the most popular medical reference text for drug information and it is referred to as the *PDR*. It also has become very popular for the public and attorneys to refer to this text, which is promoted in bookstores. Recent negotiations by the American Society of Internal Medicine's Pharmaceutical and Therapeutics Committee, conducted during the past year as a result of 1981 House of Delegates resolution, introduced by the New York State Society of Internal Medicine, have resulted in a commitment by The Medical Economics Company to publish a disclaimer in the foreward of the 1983 edition of *The Physicians' Desk Reference,* as follows: "The FDA (Food and Drug Administration) has also announced that the FD&C (Food, Drug and Cosmetic) Act does not, however, limit the manner in which a physician may use an approved drug. Once a product has been approved for marketing, a physician may prescribe it for uses or in treatment regimens or patient populations that are not included in approved labelling." Thus, the FDA states also that, "Accepted medical practice" often includes drug use that is not reflected in approved drug labelling.

The new language should discourage plaintiff attorneys from citing the *PDR* when attempting to prove drug misuse in medical malpractice suits.

I trust that this information will be worth noting by the members of the Medical Society of New Jersey as it is an attempt by attorneys in the past to cite the *PDR* as a standard of care when dealing with drug use and contraindication.

(signed) Frank J. Malta, M.D.

Handicapped Physicians

January 24, 1983

Dear Dr. Krosnick:

Do you know any physicians or medical students with a physical disability/handicap? If so, The American Society of Handicapped Physicians is seeking your participation in: advocacy, support, conference, rehabilitation, newsletter, education, and employment. Contact The American Society of Handicapped Physicians, 137 Main Street, Grambling, Louisiana 71245.

(signed) Stephen Vanna

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, The Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

May

19 Anesthesia for Neurosurgery
4-5:30 p.m.—New Jersey Medical School, Newark
(UMDNJ and AMNJ)

June

28 Anesthesia Update
8-10 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

CARDIOLOGY

May

14 Radionuclide Evaluation of Cardiac Function
8-10 p.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

27 Primary and Secondary Prevention of Coronary Artery Disease
11:30 a.m.-12:30 p.m.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

June

9 Acute Myocardial Infarction: Current Concepts and Management
8:15 a.m.-3 p.m.—Newark Beth Israel Medical Center
(Newark Beth Israel Medical Center and AMNJ)

21 Prehospital Coronary Care
12 noon—St. Mary's Hospital, Orange
(AMNJ)

MEDICINE

May

1- 217th Annual Meeting
2 Resorts International, Atlantic City
(MSNJ)

3 Medical Grand Rounds
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section of AMNJ)

4 Medical Grand Rounds
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

4 Dinner Meeting
6-9:30 p.m.—Holiday Inn, Newark Airport
(Endocrinology Section of AMNJ)

4 William P. Burpeau Annual Award-Dinner
6:30 p.m.—The Manor, West Orange
(Urology Section, AMNJ)

4 Pets and Their Diseases Transmitted from Animals to Man

11 Hearing Loss
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

4 Infectious Diseases
11 The Early Rehabilitation of the Stroke Patient
18 Angina
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

4 Internal Medicine Review Course
11 3-6 p.m.—Clara Maass Medical Center,
18 Belleville
(Clara Maass Medical Center and AMNJ)

4 Endocrine Conferences
11 3:30-5:30 p.m.—Rotates between
18 Newark Beth Israel Medical Center,
25 University Hospital, and United Hospital, Newark, and VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

4 Toxic Shock Syndrome
9-10 a.m.—Alexian Brothers Hospital, Elizabeth
(Lederle and AMNJ)

4 Nephrotoxicity
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(AMNJ)

4 Multiple Myeloma
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

5 Cystic Fibrosis
9 a.m.—Freehold Area Hospital
(AMNJ)

5 Rational Use of the Microbiology Laboratory
12:30-2:30 p.m.—Rutgers Community Health, 57 U.S. Hwy. 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

6 Medical Grand Rounds
11:30 a.m.—University Hospital, Newark
(Endocrinology Section of AMNJ)

6 Renal Conferences in Nephrology
4-5 p.m.—University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section of AMNJ)

10 Infectious Diseases
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

10 Prenatal Diagnosis, State of Art, Past, Present, and Future
8-11 p.m.—Bergen County Medical Society, Hackensack
(NJ Medical Women's Association and AMNJ)

11 Food Allergy: Fad or Fact
18 Hematology Problems
9 a.m.—Warren Hospital, Phillipsburg
(Warren Hospital and AMNJ)

12 Pruritic Rashes on One Unit
2 p.m.—John E. Runnells Hospital of Union County, Berkeley Heights
(AMNJ)

13 Current Clinical Concepts in Rheumatology/Immunology
12:15-1:15 p.m.—J.F. Kennedy Memorial Hospital, Stratford
(UMDNJ, J.F. Kennedy Memorial Hospital, and AMNJ)

14 Radionuclide Evaluation of Cardiac Function
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

17 Endoscopic Papillotomy and Common Duct Stone Extraction
12 noon—St. Mary's Hospital, Orange
(AMNJ)

17 Syndrome of Isolated Hypoaldosteronism
4-5 p.m.—Academic Health Science Center, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

17 Nephrology Lectures
7:30-8:30 p.m.—Ramada Inn, Clark
(Nephrology Society and AMNJ)

18 Newer Developments in the Treatment of Hypertension
9:30-11:30 a.m.—Riverside Hospital, Boonton
(Riverside, St. Clare's, and Dover General Hospitals and AMNJ)

18 Rutgers Dermatological Conferences
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

24 Hematologic Effects of Radiation Exposure
6:30-10 p.m.—The Landmark, Woodbridge
(NJ Blood Club and AMNJ)

25 Current Concepts in the Management of Diabetes Mellitus
8:30 a.m.-12 noon—Perth Amboy General Hospital
(NJ Affiliate, American Diabetes Association, Perth Amboy General Hospital, and AMNJ)

25 Medical Genetics
1:30-2:30 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

26 Treatment of Vasculitis
11 a.m.-12 noon—St. Joseph's Hospital, Paterson
(AMNJ)

ANNUAL AWARDS DINNER

of the

ACADEMY OF MEDICINE OF NEW JERSEY

Wednesday, May 25, 1983
6:00 P.M.
at
THE CHANTICLER
Millburn, New Jersey

1983 AWARD RECIPIENTS

EDWARD J. ILL AWARD
LEON G. SMITH, M.D.

CITIZENS AWARD
HERMAN AND ANNE R. SOMERS

HONORARY FELLOWSHIP
LEO H. SIEGEL, M.D.

GUEST SPEAKER
DANIEL CALLAHAN, Ph.D.
Director, Hastings Center

For further information, please contact EXECUTIVE OFFICES of the Academy, Two Princess Road, Lawrenceville, NJ 08648 Telephone: (609) 896-1717

June 18, 1983

THIRD ANNUAL ADVANCES IN GASTROENTEROLOGY

Golden Nugget Hotel
Atlantic City, New Jersey

Sponsored by the
Gastrointestinal Section of
The Hospital of the University of Pennsylvania
and the
Continuing Medical Education Department of
Underwood Memorial Hospital
Woodbury, New Jersey

Category I Credit offered

Information—
Registration Supervisor
Charles B. Slack, Inc.
6900 Grove Road
Thorofare, New Jersey 08086
Telephone (609) 848-1000

9th ANNUAL FAMILY MEDICINE REVIEW COURSE

June 13-17, 1983

Hyatt Regency
Baltimore Inner Harbor
Baltimore, Maryland

Sponsored by the
Department of Family Medicine
University of Maryland
School of Medicine

This course is designed to update the family physician in current concepts of medicine with emphasis on practical and clinical aspects of patient care. New diagnostic and therapeutic techniques will be presented, and major aspects of traditional care will be reviewed.

A wide variety of teaching formats will be used including lectures by nationally respected experts, live case presentations, sessions with mechanical and live patient simulators and access to videotapes and computerized learning programs.

For further information contact:

Program of Continuing Education
University of Maryland
School of Medicine
10 South Pine Street
Baltimore, Maryland 21201
(301) 528-3966

DERMATOLOGY DAYS



June 30 - July 2, 1983
CAROUSEL HOTEL
Ocean City, Maryland

Sponsored by the
Division of Dermatology
Department of Medicine
University of Maryland - School of Medicine

DERMATOLOGY DAYS will be composed of two concurrent symposia: one for the practicing generalist (internist, pediatrician and family physician), the second symposia is designed to help individual dermatologists. Dermatology Days is a symposium designed to help individual practitioners become aware of some of the most effective methods of diagnosis and management of dermatological problems as well as some of the newest advances in the field of dermatology. The course will focus on the use of live patients and much of the content will be derived from discussion of the actual cases presented.

In summary, this course will provide a comprehensive up-to-date exposure to many of the problems as well as current trends involved in the diagnosis and management of dermatological problems.

For further information contact:

Program of Continuing Education
University of Maryland
School of Medicine
10 South Pine Street
Baltimore, Maryland 21201
(301) 528-3956

28 **Update in Medicine and Surgery**
9:30 a.m.-4:30 p.m.—Philippine Ctr. Auditorium, 556 Fifth Ave., NY
(Philippine Medical Assoc. in America Inc. and AMNJ)

June

1 **Thyroid Diseases**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

1 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

1 **CDS Prescribing Practices**
11:30 a.m.-12:30 p.m.—Rahway Hospital
(AMNJ)

1 **Pulmonary: Sleep Apnea Syndrome**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(AMNJ)

1 **Management of the Diabetic Hypertensive Patient**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

2 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section of AMNJ)

3 **Medical Grand Rounds**
11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section of AMNJ)

3 **Renal Conferences in Nephrology**
17 4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section of AMNJ)

7 **Chronic Renal Failure**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

10 **Current Clinical Concepts in Rheumatology/Immunology Lecture Series**
12:15-1:15 p.m.—J.F. Kennedy Memorial Hospital, Stratford
(John F. Kennedy Memorial Hospital and AMNJ)

15 **Electromechanical Properties of Tissues Magnetic Healing of Bones**
10:30 a.m.—South Bergen Hospital, Hasbrouck Heights
(AMNJ)

15 **Detection and Management of Skin Cancer**

22 **Adolescent Sexuality**
1:30-2:30 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

15 **Rutgers Dermatological Conference**
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ-Rutgers Medical School and AMNJ)

16 **Changing Indications for Open Heart Surgery-Medical and Surgical Perspectives**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

21 **Nephrology Lectures**
7:30-8:30 p.m.—Ramada Inn, Clark
(Nephrology Society and AMNJ)

21 **Theories on the Etiology of Essential Hypertension**
4-5 p.m.—Academic Health Science Ctr., Medical Education Bldg., New Brunswick
(UMDNJ-Rutgers Medical School and AMNJ)

21 **Fluid and Electrolyte Imbalance**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

24 **Alternatives to Ileostomy and Colostomy**
12 noon-1 p.m.—Perth Amboy General Hospital
(AMNJ)

NEUROLOGY/PSYCHIATRY

May

2 **Mixed Homosexual Identity**
8:15-10:30 p.m.—9 Marquette Rd., Montclair
(Essex Psychiatric Seminar and AMNJ)

2 **Sensory Examination**
9 **Examination of the Reflexes**
16 **Behavioral Manifestations of Neurological Diseases in Children**
23 **Case Presentation**
11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

2 **Psychiatric Case Conference**
9 7:30-11:30 a.m.—Trenton Psychiatric
16 Hospital
23 *(Trenton Psychiatric Hospital and*
30 *AMNJ)*

4 **Multiple Sclerosis**
9:30-11:30 a.m.—Riverside Hospital, Boonton
(Riverside, St. Clare's, and Dover General Hospitals and AMNJ)

4 **Closet Psychiatric Patient Presenting as an Alcoholic**
3-4:30 p.m.—Fairs Oaks Hospital, Summit
(Fairs Oaks Hospital and AMNJ)

4 **Child Psychiatry Case Conference**
11 10 a.m.-12 noon—Trenton Psychiatric
18 Hospital
25 *(Trenton Psychiatric Hospital and AMNJ)*

4 **Neurology: Epilepsy**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(AMNJ)

5 **Psychosurgery: An Update**
12 **Endocrinologic Update for Practicing Neuropsychiatrists**
19 **Working with Families of Suicidal Persons**
26 **Fifth Annual John B. Atkinson Memorial Lecture in Psychosomatic Medicine**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

6 **Psychiatric Lecture Series**
1:30-5 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

12 **Topic to be announced**
8 p.m.—Hackensack Medical Center, Hackensack
(NJ Psychoanalytic Society and AMNJ)

12 **Rainer Maria Rilke, the Poet: A Psychological Study**
8-11 p.m.—Saint Barnabas Medical Center, Livingston
(NJ Psychoanalytic Society and AMNJ)

16 **Principles of Child Psychotherapy**
8:30-10:30 p.m.—Office of Lawrence Deutsch, M.D., 301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

18 **Sleep Disorders**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(NJ Academy of Family Physicians and AMNJ)

24 **Neurology**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

June

1 **A Case of Mitral Valve Prolapse Presenting as Panic Anxiety**
3-4:30 p.m.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)

1 **Child Psychiatry Case Conference**
8 10 a.m.-12 noon—Trenton Psychiatric
15 Hospital
22 *(Trenton Psychiatric Hospital and*
29 *AMNJ)*

2 **CCMA-Clinical Lectureship**
16 **Imagery and Fantasy as Therapy Techniques**
30 **Assaultive Patients-Traumatized Staff**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

6 **Preschooler's Reaction to Violent Death**
8:15-10:30 p.m.—1046 South Orange Avenue, Short Hills
(Essex Psychiatric Seminar and AMNJ)

6 **Psychiatric Case Conference**
13 7:30-11:30 a.m.—Trenton Psychiatric
20 Hospital
27 *(Trenton Psychiatric Hospital and AMNJ)*

9 **Cat Scanning in a Psychiatric Population**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

9 **Adolescent Alcoholism**
2-3 p.m.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

20 **Principles of Child Psychotherapy**
8:30-10:30 p.m.—Office of Lawrence Deutsch, M.D., 301 Broad Ave., Englewood
(New Jersey Psychoanalytic Society and AMNJ)

22 **Compulsive Gambling: A Recognized Disease**
9 a.m.-4:30 p.m.—Golden Nugget Casino, Atlantic City
(Carrier Foundation and AMNJ)

OBSTETRICS/GYNECOLOGY

May

10 **Prenatal Diagnosis, State of Art, Past, Present and Future**
8-11 p.m.—Bergen County Medical Society, Hackensack

(NJ Medical Women's Association and AMNJ)

19 **Clinical Approaches to the Patient with Ovarian Cancer**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

PATHOLOGY

May

5 **Cell Biology**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

21 **Annual Meeting**
9 a.m.-2 p.m.—Rutgers Medical School, Piscataway
(NJ Society of Pathologists and AMNJ)

25 **Transfusions**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

PEDIATRICS

May

13 **Poisoning: A Practical Approach to the Unknown Ingestion**
8:15-9:45 a.m.—Overlook Hospital, Summit
(Overlook Hospital, Columbia University College of Physicians and Surgeons, and AMNJ)

16 **Pediatric Lecture Series**
12 noon-1 p.m.—The Mountainside Hospital, Montclair
(The Mountainside Hospital and AMNJ)

24 **Controversies in Pediatric Infectious Diseases**
8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

25 **Neonatal Resuscitation and Stabilizaton Workshop**
8 a.m.-4 p.m.—Children's Hospital, United Hospital Medical Center, Newark
(Children's Hospital, UMDNJ, and AMNJ)

June

2 **Child with Dysmorphic Features**
9 a.m.—Freehold Area Hospital
(AMNJ)

10 **Changing Concepts in the Treatment of Seizures: The Value of the New Anticonvulsive Medications**
8:15 a.m.-9:45 a.m.—Overlook Hospital, Summit
(Overlook Hospital, Columbia University College of Physicians and Surgeons, and AMNJ)

20 The Floppy Infant
12 noon-1 p.m.—The Mountainside Hospital
(The Mountainside Hospital and AMNJ)

RADIOLOGY

May

5 **Interventional Radiology**
5:30-6:30 p.m.—Overlook Hospital, Summit
(Morristown Memorial Hospital, Overlook Hospital, and AMNJ)

5 **Visiting Professor Program**
26 1:30-5 p.m.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center and AMNJ)

8 **Update Arthritides**
5:30-6:30 p.m.—Overlook Hospital, Summit
(Overlook Hospital, Morristown Memorial Hospital, and AMNJ)

13 **Radiation Oncology for Cutaneous Neoplasia**
12 noon—Warren Hospital, Phillipsburg
(AMNJ)

13 **Topic to be announced**
7:30-9:30 p.m.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine and AMNJ)

14 **Advanced Echocardiography**
15 8:30 a.m.—Nassau Inn, Princeton
(The National Foundation for Non-invasive Diagnostics and AMNJ)

18 **Topic to be announced**
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section of AMNJ)

18 **Single Photon Emission Computed Tomography for the Medical Practitioner**
1-2 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

June

1 **Cost Efficient Use of Newer X-ray Techniques**
1:30-2:30 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

2 **Columbia Affiliate Radiology Lecture Series**
5:30-6:30 p.m.—Morristown Memorial Hospital
(Overlook Hospital, Morristown Memorial Hospital, and AMNJ)

11 **Real-Time, Cross-Sectional Sector Scanning**
9 a.m.-5 p.m.—Nassau Inn, Princeton
(The National Foundation for Non-invasive Diagnostics and AMNJ)

27 **Basic and Advanced Echocardiography, and Real-Time, Cross-Sectional Sector Scanning**
Sands Hotel & Casino, Atlantic City
(The National Foundation for Noninvas Diagnostics and AMNJ)

SURGERY

May

4 **Surgical Departmental Conference**
11 8:30-10 a.m.—Rutgers Medical Schoo
18 New Brunswick
25 *(UMDNJ)*

27 **High-Risk Surgery**
12 noon-1 p.m.—Perth Amboy Gener Hospital
(AMNJ)

June

1 **Surgical Departmental Conference**
8 8:30-10 a.m.—Rutgers Medical Schoo
15 New Brunswick
22 *(UMDNJ)*
29

SURGICAL SPECIALTIES (includes ENT Neurosurgery, Ophthalmology, Orthopedic, Plastics, and Vascular Surgery)

May

4 **Vascular Surgery**
10:30 a.m.—St. Mary's Hospital, Passa
(AMNJ)

5 **Leukotomy (Lobotomy): An Update**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

5 **Materials for Implantation and Their Orthopedic Applications**
6 p.m.—Ramada Inn, Clark
(Bioengineering Section, AMNJ)

5 **Vascular Conference Rounds**
12 4-5 p.m.—Rutgers Medical School,
19 New Brunswick
26 *(UMDNJ)*

June

2 **Vascular Conference Rounds**
9 4-5 p.m.—Rutgers Medical School,
16 New Brunswick
23 *(UMDNJ)*
30

MISCELLANEOUS

May

4 **Computers in Medicine**
11:30 a.m.-12:30 p.m.—Rahway Hospital
(AMNJ)

4 **Toxicology Seminars**
11 3 p.m.—Rutgers Medical School, Piscataway
(UMDNJ)

24 **A Historical View of Englewood Hospita**
8-10 p.m.—Englewood Club, Englewoo
(Englewood Surgical Society and AMNJ

OBITUARIES

Dr. Charles H. Cornish

Charles Hubbard Cornish, M.D., a member of our Essex County component, died on January 13, 1983. Dr. Cornish was born in 1905 in Elizabeth. He earned a medical degree at Cornell University Medical College, New York, in 1932. Dr. Cornish had a private medical practice in Maplewood for 47 years, specializing in obstetrics. He was affiliated with the Hospital Center, Orange. Dr. Cornish was a member of the American Medical Association. In 1982, MSNJ's Golden Merit Award was bestowed upon Dr. Cornish in recognition of 50 years as a physician.

Dr. Jose A. de Castro

At the untimely age of 49, Jose Arenas de Castro, M.D., died on December 27, 1982. Dr. de Castro earned a medical degree at the University of Santo Tomas, Philippines, in 1958. He was affiliated with John F. Kennedy Medical Center, Edison, Memorial Hospital, South Amboy, and General Hospital, Perth Amboy. Dr. de Castro was a member of our Middlesex County component and of the American Medical Association.

Dr. S.J. Della Penna

Samuel John Della Penna, M.D., died on January 25, 1983. Born in 1900, Dr. Della Penna earned a medical degree from Creighton University School of Medicine, Nebraska, in 1937. During his career, Dr. Della Penna was a surgeon at St. Joseph's Hospital, Paterson, and a company doctor for New Jersey Manufacturers Insurance Company, Clinton. Dr. Della Penna retired from practice in 1972. Dr. Della Penna was a member of our Passaic County component and of the American Medical Association and was a Fellow of the American College of Surgeons.

Dr. Fred J. Fechner

At the grand age of 82, Fred J. Fechner, M.D., died on January 25, 1983. Born in Germany, Dr. Fechner received his medical degree from the University of Heidelberg in 1926. Dr. Fechner was a family practitioner for 46 years, retiring in 1974. He was a member of our Bergen County component and of the American Medical Association. During his career, Dr. Fechner was affiliated with Hackensack Hospital.

Dr. James S. Gallo

A retired member of our Passaic County component, James Severin Gallo, M.D., died on January 15, 1983. Born in 1903 in Paterson, Dr. Gallo earned a medical degree at Columbia University College of Physicians and Surgeons, New York, in 1931. During his lengthy career, Dr. Gallo was affiliated with Greater Paterson General Hospital, Wayne, until his retirement in 1979. He was a member of the American Medical Association and a Fellow of the American College of Surgeons. Dr. Gallo was a recipient of MSNJ's Golden Merit Award in 1981 in recognition of 50 years of medical practice.

Dr. Walter J. Kossmann

At the age of 77, Walter Julius Kossmann, M.D., died on January 24, 1983. Dr. Kossmann received a medical degree from New York University in 1930. He served as school physician in Washington Township since 1933. Dr. Kossmann was affiliated with Somerset Medical Center, Somerville, and Hackettstown Community Hospital. Dr. Kossmann received the Golden Merit Award from MSNJ in 1980 for 50 years of service to the medical community. Dr. Kossmann was a member of our Morris County component and of the American Medical Association and was a Fellow of the American Academy of Family Practice.

Dr. Ronald C. Moore

At the grand age of 86, Ronald C. Moore, M.D., died on January 8, 1983. Dr. Moore earned a medical degree from Jefferson Medical College, Philadelphia, in 1919. Dr. Moore was in private practice in ophthalmology in Hammonton. He was affiliated with Kessler Memorial Hospital, Hammonton, and Center City Hospital, Philadelphia. He was an emeritus member of our Atlantic County component and a member of the American Medical Association.

Dr. John F. Perez

John Frank Perez, M.D., former chief of urology at Atlantic City Medical Center and Shore Memorial Hospital, Somers Point, died on December 23, 1982. Born in 1908, Dr. Perez received a medical degree from Georgetown University School of Medicine, Washington, D.C., in 1937. He maintained a practice in urology in Atlantic City for 45 years. Dr. Perez was a medical officer in the Army during World War II. He was a member of our Atlantic County component and of the American Medical Association.

Dr. Pia Chu Tan

Pia Chu Tan, M.D., a member of our Mercer County component, died on January 10, 1983. Born in 1909, Dr. Tan earned a medical degree at the University of Pennsylvania, Philadelphia, in 1938. He was a family practitioner affiliated with The Medical Center at Princeton. Dr. Tan was a member of the American Medical Association and a Fellow of the American Academy of Family Practice.

Dr. Gene J. Zaino

Gene John Zaino, M.D., died on January 17, 1983. Dr. Zaino was born in 1918 and earned a medical degree at the University of St. Louis, Missouri, in 1943. He was an anesthesiologist affiliated with Muhlenberg Hospital, Plainfield. Dr. Zaino was a member of our Union County component and of the American Medical Association, a Fellow of the American College of anesthesiologists, and a Diplomate of the American Board of Anesthesiology.

Basic and Clinical Pharmacology

B.G. Katzung, M.D. Los Altos, CA, Lange Medical Publications, 1982. Pp. 815. ($23.50)

In this era characterized by the introduction of drugs of dramatically different classes, of advanced generations of drugs, and of new indications for established drugs, timeliness of a pharmacology text is a valuable feature. The two years between the 1980 publication of the most recent, sixth edition of the standard text in the field, *Goodman and Gilman's The Pharmacological Basis of Therapeutics,* and this text edited by Katzung have seen major advances in the drug therapy of cardiovascular, infectious, and oncologic disorders, to name but a few fields. Newly approved drugs and drug indications are covered adequately in this volume, while drugs still under investigation generally appear to have been omitted.

Special chapters on drugs and the immune system, management of the poisoned patient, special aspects of perinatal and pediatric pharmacology, clinical interpretation of drug concentrations, and drug discovery and evaluation increase the usefulness of *Basic and Clinical Pharmacology* to special groups of readers.

This text balances quite nicely the basic science and the clinical applications of pharmacologic agents while incorporating the authoritative selectivity and conciseness of other members of the Lange series of medical texts. It should serve the needs of medical students and of practitioners.

Hyman W. Fisher, M.D.

Color Atlas of Ear Disease

Richard A. Chole, M.D. New York, NY, Appleton-Century-Crofts, 1982. Pp. 75.

As the name implies, the *Color Atlas of Ear Disease* is exactly that. It is filled with color pictures of the tympanic membrane with almost every disease that would be found in any otologist's practice or in any branch of medicine.

The quality of the pictures is excellent and they portray the diseases just as one would see them. A review of the pictures in this book certainly would give confidence to all physicians not specializing in otology. This allows them to treat an unfamiliar disease by looking at the photograph and, thereby, improving their diagnostic acumen. It would not be as useful to the otologist who easily should see most of the pathology shown in this book and be familiar with this beforehand.

To appreciate these pictures fully, the physician must realize that they were taken with an otologic telescope which is not used very extensively today. Therefore, anyone consulting this atlas should be ready to transpose the picture in the atlas to the picture that he sees during an examination. An explanation is that one cannot see the whole tympanic membrane at once with the use of a speculum. As long as the practitioner knows that he must move the speculum around while examining the ear to gather a full picture of the tympanic membrane he will be able to benefit from the atlas.

I highly recommend this book to any practitioner who, as part of his examination, must study the status of the tympanic membrane. As for the otolaryngologist, I would recommend this book to the first-year residents in otolaryngology to give full exposure to the usual ear diseases. It is obvious that it has taken many years and much experience for the author to have garnered these pictures of various and complete pathology.

Harold Arlen, M.D.

Handbook of Poisoning

Robert H. Dreisbach, M.D. Los Altos, CA, Lange Medical Publications, 1983. Pp. 632. ($11)

At the outset, I would say this is the best handbook of poisoning presently available. Texts on emergency medicine and others do not have sufficient information immediately necessary.

Every major related subject to poisoning has been noted and appropriately discussed. One excellent feature present is the description for immediate first-aid measures in poisoning noted on the inside front and back covers, with appropriate referral pages for more detailed treatment as indicated.

The table of contents is divided into six categories: general considerations, agricultural poisons, industrial hazards, household hazards, medicinal poisons, and animal and plant hazards. These categories include a total of 36 subjects. I particularly was impressed by the subject of industrial hazards, discussed in 145 pages.

The poisons not only are discussed as to symptoms, signs, and treatment, but most important is a brief and concise description on the effects of the chemicals on cellular tissue and chemical results on the blood elements as would be seen if an SMA 12 or similar test was ordered. The latter greatly enhances the significance of the results of the test with treatment and prognosis.

I heartily would recommend *Handbook of Poisoning* to every emergency physician, hospital emergency department, and industrial medical department. One subject seldom seen in this type of book is the subject on poisonous marine animals and here they are discussed and shown pictorially.

Jack R. Karel, M.D.

Management of Low Vision

Gerald E. Fonda, M.D. New York, NY, Thieme-Stratton, Inc., 1981. Pp. 248.

Management of Low Vision is a compendium of the life work of Doctor Fonda, who has been an enthusiastic researcher in the field of low vision. This book represents the knowledge derived from examining over 6,500 low vision patients and provides an excellent review

of the basics necessary to evaluate and treat patients who often are given little hope for improving their vision.

Throughout the book, Doctor Fonda's strong personal opinions and his methods of prescribing low vision aids are fostered. The need for vocational counseling, rehabilitation, social services, and genetic counseling are emphasized. The various optical aids are examined thoroughly and their optical characteristics explained.

Not all of Dr. Fonda's philosophies are accepted universally by low vision specialists. Nevertheless, Dr. Fonda's life work must be viewed as pioneering and should remind all clinicians that the words "there is nothing more that can be done" should be scrutinized carefully.

Alfonse A. Cinotti, M.D.

Modern Synopsis of Comprehensive Textbook of Psychiatry

Harold Kaplan, M.D., and Benjamin Sadock, M.D. Baltimore, MD, Williams and Wilkins Company, 1982. Pp. 1034. ($34)

This large paperback volume summarizes the third edition of *Comprehensive Textbook of Psychiatry,* edited by Kaplan, Freedman, and Sadock, a massive three-volume text published in 1980. Nearly 3,500 pages have been condensed to just over 1,000 pages even though new material was added to bring the synopsis up to date.

This is the first major textbook to discuss all psychiatric disorders according to the new nosology of the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM III). This provides operational criteria which serve to increase the reliability of psychiatric diagnosis, especially with regard to the major psychoses, schizophrenia and manic-depressive disorder (now bipolar affective disorder). The authors state that the content of the book follows the psychiatric curriculum recommendations of the National Board of Medical Examiners.

The authors are to be commended for producing such a comprehensive and easily read synopsis in a very timely fashion. Although the larger textbook contained 235 contributions by many different authors, the condensation reads very smoothly without showing much evidence of its origins.

This is the best currently available book for medical school courses in psychiatry. Residents also will find it useful although many areas will need to be amplified by consulting the many current references given in the text. Non-psychiatric physicians will find it readable and may be surprised to discover the increasingly scientific basis of psychiatry.

A. Arthur Sugerman, M.D.

Neurological Complications of Therapy

Allen Silverstein, M.D., (ed). Mount Kisco, NY, Futura Publishing Company, 1982. Pp. 470. ($49.50)

This book contains 18 essays covering the topic of toxic neurological effects from drug therapy, radiation treatment, hyperbaric oxygen, and arterial and venipunctures. There is considerable overlap with other books detailing overall toxicity from medications but in *Neurological Complications of Therapy* the attention is limited to harmful neurological effects and presented in much greater detail.

Neurologists may want to read this book cover to cover, but most of us will prefer to use this text as a definitive reference source, to read intensively on some clinical problem not well covered in the more general textbooks.

Because of the mass of detail, I found steady reading very difficult but many new facts can be gleaned by careful slow study. The price, $49.50, seems high for individual purchase, but the book deserves a place in hospital and medical school libraries.

Norman Riegel, M.D.

Problems in Pulmonary Medicine for the Primary Physician

Robert H. Israel, M.D., and Robert H. Poe, M.D., (eds). Philadelphia, PA, Lea & Febiger, 1982. Pp. 410. ($32.50)

This problem-oriented textbook, emphasizing ambulatory care medicine, is written by pulmonary physicians at the University of Rochester School of Medicine. Each chapter focuses on a distinct problem, such as a symptom, a disease, a therapeutic mode, or a method of evaluation. The first chapter on dyspnea sets a pattern. There are excellent diagrams and tables, pathophysiology, differential diagnosis including common and obscure etiologies, and x-ray correlation. There are practical recommendations, including an algorithm for step-by-step decision making. The section on cough is simple and direct and permanently should put to rest the use of the common shotgun cough preparations so widely used by both laymen and physicians.

Pulmonary function testing is outlined in step-wise manner, progressing from simple spirometry to more complex tests such as flow-volume loops. The clear diagrams are geared to the non-pulmonary physician, with indications for the use of each of these tests. The brief section on the management of a patient on a mechanical ventilator should serve as a nucleus of knowledge for the medical resident. It is not, as the presentation implies, the complete guide for any interested physician to care for a respirator patient. The section on pulmonary embolism is too brief, especially on the use of thrombolytic agents. An outline of the dosage schedule would have been helpful.

As a pulmonologist, I can say that this 410 page test is a valuable addition to the generalist and specialist's library. It should prove particularly useful as an aid to teaching house officers in the practical, how-to aspects of day-to-day management of pulmonary problems both in and out of the hospital.

Ellis P. Singer, M.D.

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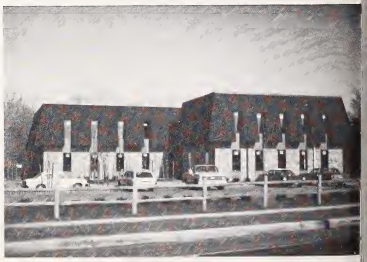
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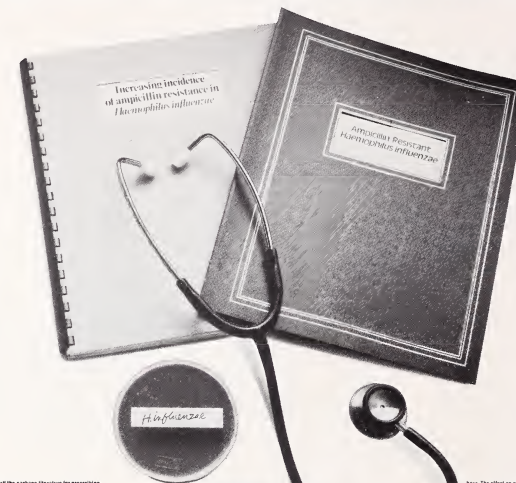
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Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication. Ceclor is contraindicated in patients with known allergy to the cephalosporin antibiotics.

Warning: BEFORE THERAPY WITH A CEPHALOSPORIN ANTIBIOTIC IS INSTITUTED, CAREFUL INQUIRY SHOULD BE ADMINISTERED CAUTIOUSLY IF THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management may include administration of fluid and electrolytes, protein supplements, and special nutritional supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile.* Other causes of colitis should be ruled out.

Precautions: General Precautions—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in serological cross-matching of blood, it should be recognized that tests are performed on the maternal side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition. It should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in hamsters given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.16, 0.25, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These usually subside upon discontinuance of therapy and may recur upon rechallenge or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Arthritis/arthralgia and carbohydrates appear to enhance resolution of the syndrome. Anaphylaxis has been reported rarely (less than 1 in 1,000) which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Clinical Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain relationship, they are listed below to serve as alerting information for the physician.

Liver—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

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Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500 or abnormal urinalysis (less than 1 in 200).

[0617826]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae.*[1]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporin antibiotics and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Neil Kramer, M.D., and Phoebe R. Krey, M.D.

Diverticulitis of Terminal Ileum
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Potentiated Anaphylaxis to Allergenic Extracts
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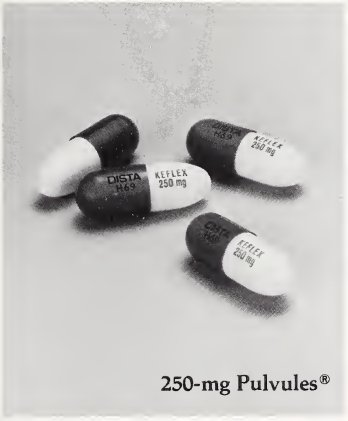
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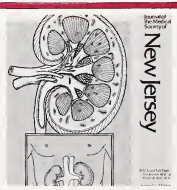
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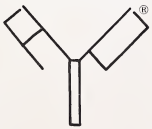
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2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis.* New York, NY, McGraw-Hill, 1969, Pp. 00-00.

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INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is a rough correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, blood pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established—Among factors that may be responsible for its antihypertensive effect in the long-term action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the force of myocardial contraction. However, beta blockade may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the therapeutic effects is unclear.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be antagonized by sympathomimetic agents that cause direct vasodilation and which should be preserved.

Propranolol is not significantly dialyzable

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for relief of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia that is greater than first degree; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with digitalis and/or diuretics in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agents and its effects can be reversed by administration of such agents, e.g. dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, dosage gradually over a period of a few weeks (see WARNINGS)

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a trademark of Ayerst Laboratories. **8520/583**

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Patient Medication Instruction Program

Along with the growing public interest in health issues and medical self-care has come an increased demand from patients for information about the drugs they take. Physicians are being called on as never before to respond with a greater emphasis on patient education.

While face-to-face counseling is an indispensable part of patient education, counseling supplemented by written information can be more effective than either alone. Furthermore, patients can keep written information for later reference.

A SERIES OF INSTRUCTIONAL LEAFLETS

In order to provide physicians with printed drug information they can use to counsel and give to patients along with a prescription, the American Medical Association has launched its Patient Medication Instruction (PMI) program. Each sheet offers the patient general, easily understood information on the purpose, use, and possible side effects of the medication, and also provides space for individualized instructions from the physician.

PMIs NOW AVAILABLE

The following 20 PMIs became available in October: furosemide, thiazide diuretics, penicillins-oral, beta-blockers, digitalis medicines, coumarin-type anticoagulants, oral antidiabetes medicines, tetracyclines, cephalosporins-oral, erythromycin, nonsteroidal antiinflammatory drugs, benzodiazepines, nitroglycerin sublingual tablets, methyldopa, insulin, cortiscosteroids-oral, cimetidine, belladonna alkaloids and barbiturates, phenytoin, and sulfonamides.

An additional 20 PMIs became available in March: lithium, haloperidol, hydralazine, guanethidine, valproic acid, ethosuximide, allopurinol, oral xanthine derivatives, thyroid replacement, metronidazole, oral clindamycin/lincomycin, oral chloramphenicol, levodopa/carbidopa and levodopa, ergot derivatives, indomethacin, phenylbutazone/oxyphenbutazone, quinidine/procainamide, iron supplements, verapamil, and nifedipine.

TYPES OF INFORMATION

PMI information is contained on 5½" x 8½" sheets printed on both sides (Figure) and includes the following information:

(1) Title and blank spaces for the patient's name, drug prescribed, directions for use, and special instructions. For single-entity drugs, the generic name will be the principal identifying designation. For combination drugs, the form will indicate the pharmacologic class of the main ingredients. Space will be provided to indicate the specific brand name(s). The physician can insert the dosage plus the frequency and method of administration—as required.

(2) "Please Read This Information Carefully." This section describes the purpose of the PMI sheet.

(3) "Uses of This Medicine." Brief and simple information on how the drug is used in therapy appears in this section.

(4) "Before Using This Medicine." This section informs the patient and reminds the physician of situations where caution should be used in prescribing the drug, such as an allergy to any medicine, pregnancy, breastfeeding, use of other medicines, or other medical conditions. In addition, other drugs that generally should not be taken in combinations with the prescribed medication are listed.

(5) "Proper Use of This Medicine." This section makes certain general statements, such as the time of day the drug usually is taken, but does not include specific dosage regimens. The patient is urged to take the medicine for the full time of treatment and instructed what to do if one or more doses are missed. Certain precautions—written to alert but not to alarm the patient—also are included. Some PMIs may contain a separate section, "Precautions While Using This Medicine."

(6) "Side Effects of This Medicine." Two classes of side effects are mentioned in this section: "Side Effects That Should Be Reported to Your Doctor" and "Side Effects That May Not Require Medical Attention." The latter are documented effects that may be anticipated, but ordinarily do not require stopping therapy. In contrast with PPIs, this section will not present a "laundry list" of all reported adverse reactions, some of which might needlessly alarm the patient.

BENEFITS VERSUS POSSIBLE RISKS

The PMI program enhances the ability of individual physicians to fulfill their responsibility to provide drug information to patients. The entire PMI sheet is presented in a manner that provides a balanced summary of anticipated benefits versus possible risks.

Physicians are able to order PMI sheets in pads of 100. On the cardboard back of each PMI pad is a list of generic and brand names of drugs falling within the class covered by the PMI, with instructions to the physician that the PMI covers only the drugs listed.

The AMA has invested more than $1 million of its own resources for the first year of the PMI program. Contributions in excess of $1.9 million have been made by major

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse who are, respectively, Director of the Department, and Director of Special Projects.

PMI 002 **Thiazide Diuretics**

Patient Medication Instruction Sheet

For: _____

Drug Prescribed: _____

Directions for Use: _____

Special Instructions: _____

Please Read This Information Carefully

This sheet tells you about the medicine your doctor has just prescribed for you. If any of this information causes you special concern, check with your doctor. **Keep this and all other medicines out of the reach of children.**

Uses of This Medicine

This medicine is commonly used to treat high blood pressure. It also is used in heart and kidney problems to help reduce the amount of salt and water in the body by increasing the flow of urine. Thiazide diuretics also may be prescribed for other conditions as determined by your doctor. Take this medicine only as directed by your doctor.

Before Using This Medicine

BE SURE TO TELL YOUR DOCTOR IF YOU. . .

- are allergic to this medicine or to sulfa drugs;
- are pregnant or intend to become pregnant while using this medicine;
- are breastfeeding;
- are taking any other prescription or nonprescription medication, or have any other medical problems.

Proper Use of This Medicine

DOSAGE

When you begin to take this medicine, you may notice an increase in the amount of urine or in your frequency of urination. In order to keep the increase in urine from affecting your nighttime sleep, follow this regime:

- If you are to take a single dose a day, take it in the morning after breakfast.
- If you are to take more than one dose a day, take the last dose no later than 6 p.m. unless otherwise directed by your doctor.

If you miss a dose of this medicine, take it as soon as possible unless it is almost time for your next dose. In this case, do not take the missed dose at all and do not double the next one. Instead, go back to your regular dosing schedule.

FOR HIGH BLOOD PRESSURE

If high blood pressure is not treated, it can cause serious problems such as heart failure, blood vessel disease, stroke, or kidney disease. Remember that this medicine will not cure your high blood pressure, but it does help control it. Therefore, **you must continue to take the medicine as directed—even if you feel well—**if you expect to keep your blood pressure down.

Precautions While Using This Medicine

This medicine may cause a loss of potassium from your body. To help prevent this your doctor **may** want you to:

- eat or drink foods that have a high potassium content (for example, orange or other citrus fruit juices); or
- take a potassium supplement; or
- take another medicine to help prevent the loss of potassium in the first place; or
- reduce your salt intake and/or use a salt substitute.

Be sure to check with your doctor, however, before changing your diet on your own. Loss of appetite, vomiting, or diarrhea may cause a further loss of potassium and you should inform your doctor if these events occur.

Do not take other medicines unless they have been discussed with your doctor. This especially includes over-the-counter (OTC) or nonprescription medicines for appetite control, asthma, colds, cough, hay fever, or sinus, since they may tend to increase your blood pressure.

Side Effects of This Medicine

SIDE EFFECTS THAT SHOULD BE REPORTED TO YOUR DOCTOR

- Increased sensitivity of skin to sunlight
- Increased thirst
- Loss of appetite
- Irregular heartbeat
- Skin rash or hives
- Nausea and vomiting
- Severe stomach pain
- Unexplained sore throat and fever
- Unusual bleeding or bruising
- Unusual tiredness or weakness
- Yellowing of eyes or skin

SIDE EFFECTS THAT MAY NOT REQUIRE IMMEDIATE MEDICAL ATTENTION BUT SHOULD BE REPORTED TO YOUR DOCTOR IF THEY PERSIST MORE THAN A DAY OR TWO

- Diarrhea
- Dizziness or light-headedness when getting up from a lying or sitting position
- Decrease in sexual ability
- Muscle cramps or pain
- Upset stomach

The information in this PMI is selective and does not cover all the possible uses, actions, precautions, side effects, or interactions of this medicine.

This PMI is produced by the AMA, which assumes sole responsibility for its content. Appreciation is acknowledged to the other organizations that provided assistance and information to the AMA and, in particular, the U.S. Pharmacopeia.

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Figure—Sample PMI form.

pharmaceutical manufacturers for implementation of the program, primarily for printing and production costs.

The PMI program is not intended as a substitute for the instruction on drugs that physicians give each patient. Neither is it an attempt to provide a legal instrument of informed consent or complete data. Rather, the program is meant simply to offer appropriate drug information in a manner that will benefit the patient by augmenting discussion with the physician.

The PMI program can benefit both physician and patient by improving the effectiveness of drug therapy, strengthening the physician/patient relationship, reducing the risk of improper use, decreasing the incidence of preventable and serious adverse drug reactions, and enhancing patient compliance.

The AMA's Patient Medication Instruction program demonstrates professional concern about patients' participation in their health care. It shows a commitment to activities designed to promote the quality of medical care while addressing the cost of care.

PMIs are bound in pads of 100 and are available at a cost of 50 cents a pad to defray postage and handling. The minimum order is five dollars for ten pads. Doctors who would like to request samples or order blanks should write to AMA Order Department, PMI Program, 535 North Dearborn Street, Chicago, IL 60610.

Brief Prescribing Information

CONTRAINDICATIONS: Patients with severe hypertension, severe coronary artery disease, and in patients on MAO inhibitor therapy, narrow-angle glaucoma, urinary retention, peptic ulcer, during an asthmatic attack.

Hypersensitivity: Contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines or phenanthrene derivatives.

Nursing Mothers: Contraindicated because of the higher than usual risk for infants from sympathomimetic amines.

WARNINGS: Use judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy. May produce CNS stimulation and convulsions or cardiovascular collapse with accompanying hypotension.

Use with caution in patients with increased intraocular pressure, cardiovascular disease, hypertension or in patients with a history of bronchial asthma. Do not exceed recommended dose.

Use in Elderly: The elderly (60 years and older) are more likely to have adverse reactions to sympathomimetics. Overdosage in this age group may cause hallucinations, convulsions, CNS depression and death.

PRECAUTIONS: *General:* Should be used with caution in patients with diabetes, hypertension, cardiovascular disease and hyperreactivity to ephedrine. The antihistaminic may cause drowsiness and ambulatory patients who operate machinery or motor vehicles should be cautioned accordingly.

Information for Patients: Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery, and mental alertness in children.

Drug Interactions: MAO inhibitors and beta adrenergic blockers increase the effect of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids. Concomitant use of antihistamines with alcohol, tricyclic antidepressants, barbiturates and other CNS depressants may have an additive effect.

Pregnancy Category C: Animal reproduction studies have not been conducted with NOVAFED A capsules. It is also not known whether NOVAFED A capsules can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. NOVAFED A capsules may be given to a pregnant woman only if clearly needed.

Nursing Mothers: Pseudoephedrine is contraindicated in nursing mothers because of the higher than usual risk for infants from sympathomimetic amines.

ADVERSE REACTIONS: Hyperreactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness, or nausea. Patients sensitive to antihistamines may experience mild sedation. Sympathomimetic drugs have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CNS depression, arrhythmias, and cardiovascular collapse with hypotension.

Possible side effects of antihistamines are drowsiness, nervousness, dizziness, weakness, dry mouth, anorexia, nausea, headache, nervousness, blurring of vision, heartburn, dysuria and very rarely dermatitis. Patient idiosyncrasy to adrenergic agents may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

OVERDOSAGE: Acute overdosage with NOVAFED A capsules may produce clinical signs of CNS stimulation and variable cardiovascular effects. Pressor amines should be used with great caution in the presence of pseudoephedrine. Patients with signs of stimulation should be treated conservatively.

DOSAGE AND ADMINISTRATION: One capsule every 12 hours. Do not give to children under 12 years of age.

CAUTION: Federal law prohibits dispensing without prescription.

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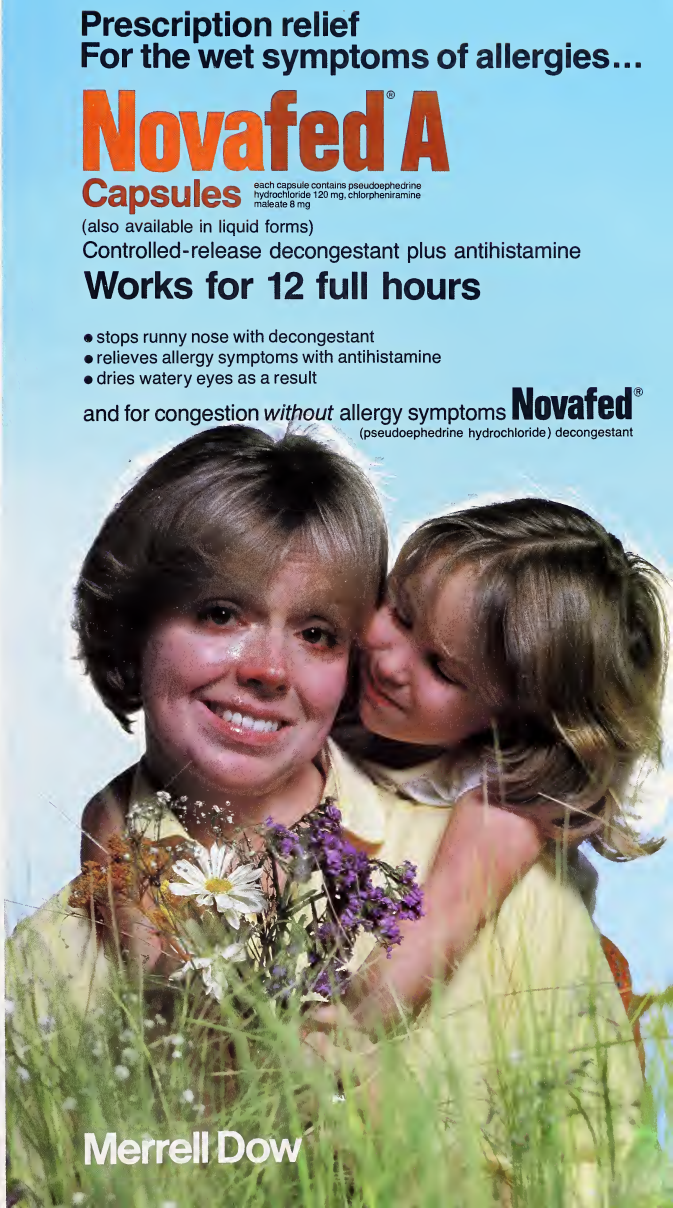
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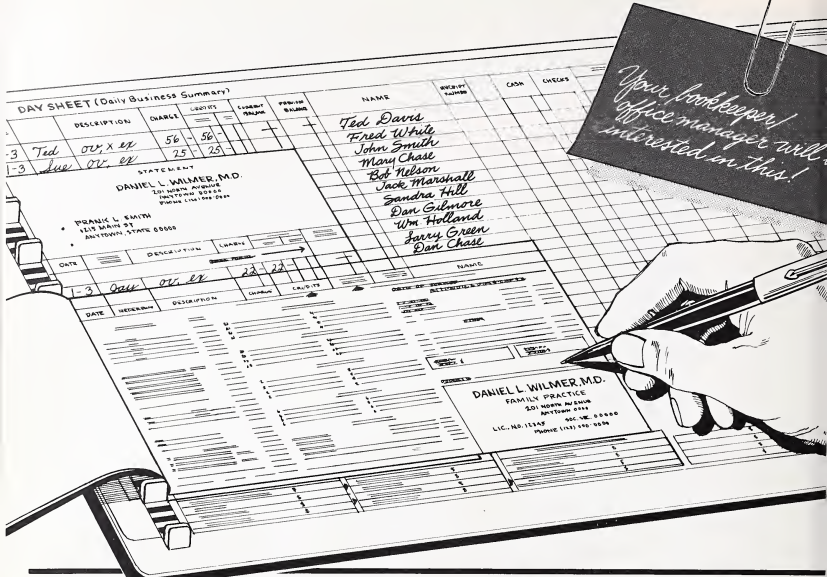
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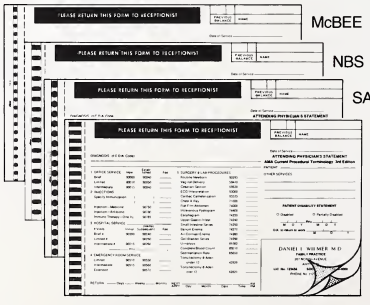
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'Tis The Season

As Tennyson said, "In the spring a young man's fancy lightly turns to thoughts of love," and a home owner's fancy turns to gypsy moths. These caterpillars are voracious creatures that will emerge from their egg clusters between April 15 and June 15. Their favorite foods are leaves of oak, birch, and willow trees.

The annual rite of the gypsy moth caterpillar brings many inquiries to the Department of Environmental and Community Medicine, UMDNJ-Rutgers Medical School. These questions invariably concern the potential adverse effects of the agents used to control the caterpillar.

Many of the inquiries also are addressed to local medical societies and to family physicians. The question usually is phrased as a statement, "They are going to spray my area for gypsy moths, what should I do? What is the risk?"

There are several factors that come into play when one is considering hazard and risk. One must consider first, the chemical agent(s) being used; second, the toxicity of a given agent under the proposed use conditions; third, the level of the compound (dose) and the population being exposed; and last, the potential benefits.

It should be emphasized that toxicity is the result of dose; hazard is a function of toxicity and exposure; and risk is a probability of a hazard being manifested under a given set of circumstances. Hence, if there is no exposure there is no hazard. The risk-free case is no spraying at all. The reality of the situation is that many homeowners and municipalities want to protect their investments in trees and will attempt to control the caterpillar populations.

The compounds used to control gypsy moth caterpillars in New Jersey are carbaryl (Sevin) and *Bacillus thuringiensis* (BT). The major concern is with the application of carbaryl. This compound (1-naphthyl-N-methylcarbamate) is a reversible cholinesterase inhibitor of relatively low acute toxicity (oral LD 50 of approximately 540 mg/kg; dermal LD 50 greater than 5000 mg/kg).[1]

The greater concern with carbaryl is raised over the issue of carcinogenicity, mutagenicity, and teratogenicity. Several rodent carcinogenicity studies have been completed on carbaryl. These studies have been conducted by the manufacturer and others and to date all have been negative. These generally are lifetime feeding studies at maximum tolerated doses. The doses in this type of study have produced signs of overt toxicity such as marked depression of serum cholinesterase or a major suppression in body weight.[2-5]

The studies conducted to determine the potential of carbaryl to induce mutations have been conducted in several strains of microorganisms and Drosophila.[6] Positive results in mutagenicity tests are well correlated with positive carcinogenicity tests in laboratory animals. The mutagenicity tests, in general, are negative.[6-8] Hence, these results support the negative cancer studies. Some studies have been conducted using nitrosated derivatives of carbaryl in the mutagenicity screens.[9-10] Indeed, the studies have shown mutagenic potential of the nitrosated carbaryl. However, these derivatives were made in the laboratory and not under field use conditions.

Teratogenicity (ability to induce birth defects) raises the most outcry and alarm. It has been shown that carbaryl induces birth defects in laboratory dogs.[11-12] These studies showed that dogs treated with 6.3 mg/kg body weight throughout gestation yielded pups with skeletal and soft tissue defects. No effects were noted at 2.0 mg/kg.[12] Studies in laboratory rodents (rats) did not support the findings in dogs.[13-16]

Other studies were conducted in rabbits which showed carbaryl to be teratogenic and fetotoxic at doses that were overtly toxic to the maternal animal.[17] Studies also have been conducted in Rhesus monkeys and the results of these studies indicate that carbaryl is not teratogenic.[18,19]

To elucidate the possible mechanism(s) of the teratogenic effect in dogs as compared to other species, a series of studies were undertaken to determine if a species difference in metabolism of carbaryl could explain the species difference in teratogenicity. The results of these studies indicate that in man, monkey, and rodents there are at least 3 to 5 major metabolites while in the dog none of these compounds are metabolites.[20-21] The metabolites in the dog were dissimilar from man and also there was a quantitative difference in the metabolites; i.e. the dog had metabolites seen in other species but at much different levels.[21] It is known that dogs do not metabolize amines to the same extent or in the same manner as man, and it is thought that these differences in metabolic pathways render the dog susceptible to carbaryl teratogenicity.

It also should be kept in mind that carbaryl is approved by the EPA as a 5 percent active ingredient in flea and tick powder for use on dogs. This usage indicates that carbaryl is not absorbed through the skin.

Carbaryl also is approved for use on food crops and the tolerance for residue is 5 to 12 parts per million (ppm). The acceptable daily intake set by WHO for carbaryl is 0.01 mg/kg/day.[1] This level is several times the level one would receive if directly sprayed and if it were absorbed per-

cutaneously. The results of this analysis indicate that carbaryl as Sevin does not present an acute hazard, and under the conditions of use does not represent a long-term hazard.

The second treatment widely used in New Jersey is *Bacillus thuringiensis* (BT). This product is a bacterial spore that is sprayed much the same way as carbaryl and is inherently less toxic. Whereas carbaryl is a cholinesterase inhibitor in all species, BT basically is only effective against caterpillars. Its mechanism of action is by release of crystals in the GI tract of the caterpillar. These crystals disrupt the tract and cause death. BT must be consumed by the pest while carbaryl acts as both a systemic poison and a contact pesticide. Several studies have been carried out with BT. It is not acutely toxic to mammals and because it is a spore one would not expect long-term health effects from BT exposure. The precautions for BT need not be as stringent as those for carbaryl but a prudent approach is to avoid contact during spraying or contact with surfaces wet from the spray.

A problem with gypsy moths that is becoming more evident is the elicitation of an allergic dermatitis from contact with the caterpillar.[22] This reaction has been reported in both laboratory workers and the general population, and has been cited by the Centers for Disease Control.[23]

In summary, the gypsy moth is here to stay. The problem of control comes up each spring and practitioners in New Jersey are going to be sought out for advice. There is no need or place for panic or hysteria. The advice given by the Department of Environmental and Community Medicine, UMDNJ-Rutgers Medical School is to avoid contact with any pesticide being sprayed. Wash off exposed surfaces where children play as well as any outdoor eating surface. Swimming pools generally need not be covered as carbaryl and BT are not absorbed through the skin to any extent.

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Environmental and Community Medicine
UMDNJ-Rutgers Medical School

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JMSNJ Honored

The Journal of the Medical Society of New Jersey has been awarded first honorable mention in the State Medical Journal category of the Eighth Annual Sandoz Medical Journalism Competition. This is the first year *The Journal* has received such an honor.

The criteria for the award primarily are good design and writing. As Craig D. Burrell, M.D., Vice-President of External Affairs, Sandoz, Inc., wrote, "The judging was extraordinarily difficult because of the large number of excellent publications in your category, including several which recently have been considerably improved."

First prize went to *The Journal of the Florida Medical Association*. Special awards went to *Michigan Medicine, Virginia Medicine, Journal of the Iowa Medical Society,* and *Pennsylvania Medicine.* Honorable mentions also were given to *Journal of the Oklahoma State Medical Association, Colorado Medicine,* and *Journal of the Tennessee Medical Association.* G.H.

Leon G. Smith, M.D., 1983 Edward J. Ill Award Recipient

Leon G. Smith, M.D., Director of Medicine and Chief of Infectious Diseases at Saint Michael's Medical Center, Newark, has been named the recipient of the Edward J. Ill Award. This award, granted by The Academy of Medicine of New Jersey, is bestowed upon a "New Jersey physician for dedication and extraordinary service to the profession and the citizens of the state."

The Academy of Medicine will present the Edward J. Ill Award to Dr. Leon Smith at its Annual Awards Dinner on May 25, 1983, at The Chanticler in Millburn.* The original award was presented in 1939 in honor of the Academy's first president. Recent recipients include Drs. Arthur Krosnick, James Rogers, James Todd, Lena Edwards, Victor Parsonnet, and Arthur Bernstein.

A member of our Essex County component, Dr. Smith is a Diplomate of the American Board of Internal Medicine and of the American Board of Infectious Diseases, a Fellow of the American College of Physicians, and a member of the American Medical Association. Dr. Smith is a professor of medicine and of preventive medicine and community health at the University of Medicine and Dentistry. In addition, Dr. Smith is a member of the Editorial Board of *The Journal*.

Dr. Leon Smith established the state's first viral diagnostic laboratory, the state's first sexually transmitted diseases laboratory, and the state's first nosocomial laboratory. He is credited with introducing over 40 infectious diseases specialists in New Jersey as well as the training of over 2,000 medical interns and residents while director of medicine at Saint Michael's Medical Center.

Dr. Smith was instrumental in the establishment of a state pediatric infectious diseases department and the state's only *Chlamydia* laboratory, now the largest on the east coast.

*For more information on the Annual Awards Dinner, contact The Academy of Medicine of New Jersey, 609-896-1717.



Leon G. Smith, M.D.

Dr. Smith has served as president of The Academy of Medicine and as AMNJ's medical education chairman. He is the author of six books and over 60 publications.

In addition to his work at Saint Michael's Medical Center and UMDNJ, Dr. Smith is a dedicated community leader. He is a frequent participant on area radio and talk shows, answering medical questions from the public. G.H.

Narcotics Prescribing Is (Can Be) Dangerous Business

Many professionals feel that the community standard for prescribing controlled dangerous substances (CDS) lags far behind acceptable criteria. For this and other reasons, physicians must be alert to the proper approach in the prescribing of CDS, aware of pitfalls, and informed about ways to prevent the misuse, abuse, and illicit diversion of properly prescribed CDS medical products.

To this end, educational programs to elevate the awareness of all prescribing professionals are being developed by the Medical Society of New Jersey, The Academy of Medicine of New Jersey, and the New Jersey State Department of Health.

In addition, MSNJ and the Department of Health are creating a consultant service that will be available regionally; the service will answer questions about proper prescribing and other problems related to the proper and improper usage of CDS, but there is no intention to limit the appropriate and proper prescription of controlled dangerous substances. However, there is a need for all professionals to be aware of and to use up-to-date treatment plans. The pharmaceutical companies themselves recognize the problem of tolerance and addiction, and many have revised their indications for the use of CDS.

CDS are controlled and dangerous, and agencies exist to monitor these substances from manufacture to patient use. Careless prescribing may place the physician afoul of federal or state law and the New Jersey Medical Practices Act.

Well-meaning physicians even may find their licensure in jeopardy because they lack current knowledge of the product they are prescribing, so each physician must update his knowledge of proper prescribing frequently and regularly.

Obviously, questioning a patient concerning possible abuse of controlled substances can strain the doctor-patient relationship. When the doctor suggests that a patient possibly is becoming addicted, the patient usually denies it. In

such an instance, it may be wise to seek an independent consultant in order to salvage the relationship. In fact, a written second opinion should be obtained when a CDS is used for other than standard indications.

To assist physicians in dealing with these problems, suggested guidelines are shown in the Table.

Remember that the State Board of Medical Examiners has the power to take licenses away from those who innocently or unknowingly do not use extreme care in prescribing and providing controlled dangerous substances. The physician is responsible for the control of the dangerous substances.

The continuing medical education programs that are being developed to deal with the problems of prescription drug misuse, abuse, and diversion now are voluntary. If each physician does not take positive action to be certain of his own current knowledge in this area, these programs may become mandatory. The right to prescribe is precious to the medical profession. Protect that right by prescribing properly.

Richard J. Corbett, M.D.
Chairman, Ad Hoc Committee on Drug and Alcohol Abuse
Edwin A. Turner, Jr., M.D.
Member, Ad Hoc Committee on Drug and Alcohol Abuse

TABLE
10 Commandments for Proper Prescribing

1. Never prescribe without a properly recorded history and physical examination.
2. Be suspicious when the patient suggests what to prescribe.
3. Give telephone prescriptions only for your regular patients for well-established reasons.
4. Prescribe in small amounts only.
5. Refill only at office visits or for exceptional other reasons.
6. Be suspicious of "lost" or "spilled" as excuses for extra prescriptions. (These are common pretexts used to supply friends and family members with these substances).
7. Directly confront repeated offenders who have suspicious requests or uses. Your license and reputation are at stake.
8. Be careful to prevent theft of prescription pads.
9. Be very wary of manipulative patients who may attempt to obtain drugs in order to redirect their distribution.
10. Do not have your DEA number printed on prescription blanks. Write it when you write the prescription.

Doctor: Did You Mean What You Wrote?

We physicians have extensive and intensive education, but too often we fail to communicate ideas for a variety of reasons. This especially is true with hastily written or dictated clinical notes.

Witness the following extract from a hospital discharge summary: "Disposition: The patient was discharged on December 17, 1982, being afebrile, ambulatory, moving her bowels, and voiding."

A literal view of that scene might shock the visiting chaplain if he happened upon it on his hospital rounds. Obviously, the doctor-author did not mean what he wrote. The syntax of that sentence is both unacceptable and confusing, yet we can guess its true content.

The following gem is part of an informed consent form and agreement for oral surgery: "Naturally there is expected some swelling, bleeding, stiffness, and discomfort. Rarely occurring complications are loss of fillings, other teeth fracturing, other teeth loss, extensive sinus involvement, extensive infection, broken jaw, part of tooth left in, temporary or permanent numbness and/or pain to parts of the mouth and face, and other problems which will be described on request. In the course of surgery additional and/or different treatments may become necessary and done without further notice. General anesthesia and extremes of age increase risk of mouth and general body complications and life. Our preoperative, operative, and postoperative care and medications will reduce these factors and have you as physically and emotionally comfortable as possible. You will probably be surprised at how well it all goes!"

The reader probably will be surprised, doctor, if he is fortunate enough to survive, but he may walk to the nearest exit before he finds out.

Physicians write or dictate mountains of materials, but they pay little attention to the quality of their writing. Thus, the results provide an endless stream of material for such critical publications as *The Underground Grammarian** but they also represent a personal and national disgrace and a potential legal threat.

Among the writings we regularly produce are: history and physical examination reports; progress notes; informed consent forms; operative notes; x-ray reports; EKG and other test interpretations; letters to colleagues, insurance companies, lawyers, editors, and others; and discharge summaries.

Some of us write medical and scientific articles and, despite years of reading journals and textbooks filled with such material, produce results that are not much better than the previous examples.

In order to assist our readers to write better material, *The Journal* will publish a series of articles which will deal with techniques of writing simply and clearly in order to communicate ideas in an unambiguous way. We hope this feature will prove helpful. A.K.

*Published monthly, September to May, Glassboro, NJ.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. ℞ only.

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Professional Liability Insurance as a Condition for Staff Membership

In the past decade, hospitals have created increasingly stringent requirements for medical staff membership. This trend can be traced to the increase in medical malpractice litigation, and even more particularly to the landmark judicial decision in the case of Darling v. Charleston Memorial Hospital, 211 N.E. 2d 253 (1965), cert. denied 383 U.S. 946 (1966).

In the Darling case, the court ruled that a hospital may be held liable for injuries to patients resulting from medical malpractice on the part of a medical staff physician where the hospital negligently failed to monitor the physician's work.

The potential for the joint liability of the hospital and physician in malpractice cases has prompted hospitals to become more selective in appointing and reappointing physicians to their medical staff. The threat of joint liability also has prompted hospitals to impose professional liability insurance requirements as a condition for continued medical staff membership.

Available data indicates that the vast majority of physicians carry professional liability insurance. However, physicians occasionally drop their coverage for philosophical or other reasons. Do hospitals have a legal right to require professional liability insurance as a requirement for medical staff privileges?

While no New Jersey court has rendered an opinion on this question, the answer appears to be yes. Courts that have considered insurance requirements have found them to be reasonable in light of the reality of current practices in medical malpractice litigation.

In the case of Holmes v Hoemako, 573 P2d 477 (1978), the Supreme Court of Arizona outlined its reason for upholding a hospital's insurance requirements as follows: "We cannot ignore the realities of modern procedural practice. If a patient is injured while in a hospital, regardless of who is at fault, the hospital will almost always be joined as a codefendant. Despite the outcome of such action, the hospital must expend valuable financial resources in its own defense, and will, if innocent of wrongdoing, be more likely to recover its expenses from the tort-feasor physician if that physician is insured. If, indeed, some conscientious lawyer decides not to include the hospital in an action where the finger of negligence points directly and solely to the doctor, we can be certain it will be only because the physician does indeed have malpractice insurance."

In addition to the concerns expressed by hospitals, some insured members of the medical staff may resist working in association with an uninsured physician. The risk of being joined in litigation against a colleague is enhanced greatly when the colleague is uninsured.

In a few states, malpractice insurance coverage is a mandate for medical licensure. In states without this requirement, hospitals may require proof of current liability insurance in certain dollar amounts or other form of assurance, such as an agreement on the part of the uninsured physician to indemnify the hospital and other medical staff members.

Given the availability of malpractice insurance, it is likely that courts will continue to uphold mandatory liability insurance as a condition of medical staff membership.

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*The material for this column is coedited by Arthur Krosnick, M.D., Editor of *The Journal;* Vincent A. Maressa, Executive Director, MSNJ; and James E. George, M.D., J.D., Director of the Department of Professional Liability, MSNJ.

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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Interstitial Cellular Components in the Kidney of Man and Other Vertebrates

J.R. RAVENS, M.D., J.A. AGUAYO, M.D., M.A. PORTO, M.D.,
H.R. KRANZLER, M.D., Piscataway*

In this study, the cytomorphologic findings provide evidence that the interstitial cells exist in the kidney of man and other vertebrates as an integral cellular component. Our findings suggest that they play an active role in the mechanisms of transport, protection, support, and defense.

Throughout the interstitium of the renal substance, interspersed among the blood vessels and tubules, there exists a reticulum of fine connective tissue fibers. Intertwined throughout this network is a vast plexus of cells which embraces the renal tubules and capillaries and represents the mesenchymal cellular component of the kidney.

The existence of this interstitial cell population was first noted by Hessling[1] and subsequently was mentioned briefly by Beer,[2] Beckmann,[3] Ludwig,[4] and Wittich.[5] However, detailed description of these cells was not forthcoming until the turn of the century when Retterer[6] and Renaut and Dubreuil[7] described them in the renal medulla.

Subsequent to these early reports, limited studies of the morphology of this particular cell type have been undertaken. In 1921, Rio Hortega described stellate cells which surround the loop of Henle.[8] In the same year Lubarsch noted such cells around the capillaries of the renal interstitium.[9] Costero and Suarez-Lopez, while studying inflammatory conditions and fibrosis of the glomerulus, found stellate cells surrounding the glomerular basement membrane.[10] These cells formed anastomoses via thin cytoplasmic extensions and thereby embraced the structure. Vimtrump and Schmidt-Nielson recognized the presence of interstitial cells in the medulla of the kangaroo rat, at the level of the narrow zone and the junction of the middle and distal thirds of the papilla.[11] Sternberg, Farber, and Dunlap found such interstitial cells in close association with the tubules at the level of the renal papilla of the rat.[12] Studies concerning the interstitial cells of the kidney were summarized and amplified by Polak and Schlossberg[13] and Ravens.[14,15]

The application of reliable metallic impregnation methods (i.e. ammoniated silver nitrate and silver sulfate) developed for this purpose by J.R. Ravens, has enabled us to selectively demonstrate these cells in the kidney of man and other vertebrates. In this manner we have been able to study, in the normal condition, the topographic distribution and morphology of these cells at different levels of the renal cortex and medulla.

MATERIALS AND METHODS

A total of 200 kidneys were obtained for the study. Of this total, 128 were from a variety of animals including: 13 rats, 10 guinea pigs, 10 rabbits, 3 raccoons, 4 cats, 5 dogs, 2 calves, 5 sheep, 3 pigs, 1 brown deer, 3 cows, 1 horse, and 4 squirrel monkeys. The remainder were obtained from 36 unrelated autopsied patients who ranged in age from 1 to 25 years.

The material was fixed in 10 percent formaldehyde (1 part 40 percent commercial formalin and 4 parts water) and 15 percent neutral formaldehyde (15 gm calcium carbonate and

*From the Department of Pathology, UMDNJ-Rutgers Medical School, Piscataway. Correspondence may be addressed to Dr. Ravens, UMDNJ-Rutgers Medical School, Piscataway, NJ 08854.

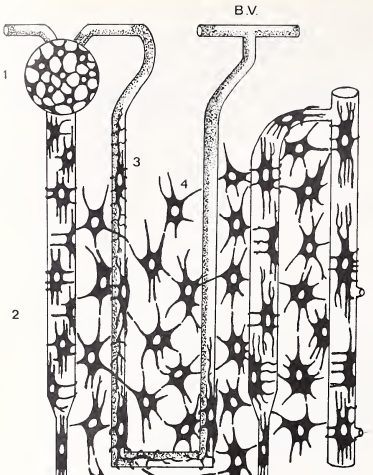


Figure 1—Histodiagram illustrating the different types of interstitial cells: 1: Periglomerular cells (Type 1, Costero and Suarez-Lopez cells); 2: Peritubular cells (Type II, Rio Hortega-Sternberg cells); 3: Perivascular cells (Type III, Lubarsch cells); 4: True interstitial cells (Type IV, Vimtrump cells); B.V., capillary blood vessel; and N, nephron and its components.

1000 cc of 40 percent commercial formalin) for varying periods of time (i.e. 6, 12, 24, 36, 72, and 96 hours). The most effective time for fixation varied between 24 and 36 hours.

Thick sections from representative areas of the kidney were taken for examination. The selective silver impregnation methods were applied to frozen tissue sections to demonstrate the cells of the renal interstitium.

RESULTS

The histologic techniques have demonstrated the distribution and morphology of the cells of the renal interstitium.

With the selective metallic impregnation techniques, we were able to identify four types of interstitial cells: periglomerular, peritubular, perivascular, and true interstitial, as shown in Figure 1. These cells vary in distribution at different levels of the cortex and medulla. They are interspersed among the interstitial connective tissue fibers, a delicate network of collagenous and reticular fibers enmeshing the renal tubules and capillaries. The interstitial connective tissue is scanty in the cortex, but increases markedly in the medulla and is most abundant in the pyramids. The distribution of the interstitial cell population is directly proportional to the distribution of connective tissue. Moreover, in the comparative study of rats, rabbits, dogs, sheep, pigs, and humans, increased body size was correlated positively with both increased numbers of interstitial cells and increased interstitial space.

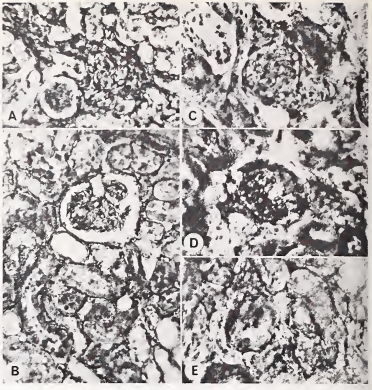


Figure 2—Photomicrograph of the periglomerular interstitial cells (Type I): **A:** Rabbit kidney (tangential section of the glomeruli) showing stellate-shaped cells and their tendency to anastomose (ammoniated silver nitrate impregnation); **B:** Human kidney (sagittal section of the glomeruli), with fine and delicate cellular structures surrounding Bowman's capsule (ammoniated silver nitrate impregnation); **C, D, and E:** Kidneys of dog, monkey, and pig, respectively (tangential section of the glomeruli), illustrating these cells (silver sulphate impregnation).

The cells of the renal interstitium are irregular, elongated, fusiform, or stellate in shape and demonstrate varying numbers of thin or thick cytoplasmic extensions. These processes extend outward for a variable distance and may be in contact with: another cell body or its cytoplasmic extension; renal tubules; or renal capillaries. Their nuclei are round or oval with little chromatin, a thin nuclear membrane, and a prominent angular nucleolus. The cytoplasm is scanty, but it demonstrates an intense affinity for metallic salts (argentophilia). The feature that best distinguishes the different interstitial cell types is their orientation relative to other renal structures. That is, they may be grouped around the glomeruli (Type I), in contact with the renal tubules or capillaries (Types II and III), or randomly distributed in the interstitium (Type IV).

Type I, Periglomerular Cells (Costero and Suarez-Lopez Cells). These cells are flattened and distributed around the periphery of the glomerulus, as shown in Figures 2A and 2D. They are entrenched among the external surface of Bowman's capsule and the blood vessels and tubules. Periglomerular cells display both short and long cytoplasmic extensions which embrace the surface of the glomerulus and frequently anastomose with neighboring cells. Figure 2A clearly illustrates these characteristics.

Type II, Peritubular Cells (Rio Hortega-Sternberg Cells). These cells are situated along the proximal tubules, loop of Henle, distal tubules, and collecting ducts, and are most abundant of the four types of interstitial cells (Figures 3A to 3E). They are stellate, with short and thick or long and thin cytoplasmic processes which embrace the tubules as seen in Figures 3B to 3E. The cytoplasmic extensions are oriented in a bipolar manner. On one side they partially embrace the surface of one or more tubules (tubular pole), while on the opposite side they are attached to the surface of one or more

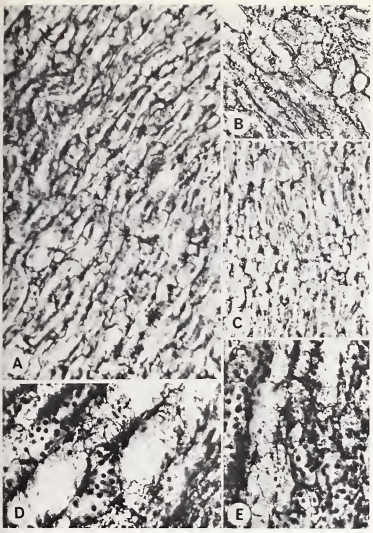


Figure 3—Photomicrographs of the peritubular interstitial cells (Type II): **A, B, C:** Human kidneys (longitudinal and cross sections of the tubules), demonstrating the distribution of these cells along the renal tubules (ammoniated silver nitrate impregnation); **D, E:** Rat kidneys (oblique section of the tubules), clearly illustrating the cytoplasmic extensions of these cells and their relations with the surrounding structures (silver sulphate impregnation).



Figure 4—Photomicrographs of the perivascular interstitial cells (Type III): **A:** Cow kidney, showing the fine capillary-blood vessels surrounded by perivascular cells (ammoniated silver nitrate impregnation); **B:** Raccoon kidney, showing a segment of blood vessel at high magnification, with perivascular cells embracing the structure (ammoniated silver nitrate impregnation).



Figure 5—Histodiagram demonstrating the bipolar attachments of the peritubular cells: A: peritubular cells; a: cytoplasmic extensions attached to the periphery of the tubules (tubular pole); b: cytoplasmic extensions connected to the capillary-blood vessels (vascular pole); T: renal tubules; and B.V.: capillary-blood vessels.

blood vessels (vascular pole). These observations are demonstrated in Figure 5. Another characteristic feature of these cells is the presence of vesicles which, although found throughout the cytoplasm, appear to be more numerous at the poles of the cells.

In the rat, at the level of the collecting ducts, these cells are elongate and form a parallel, "leather-like" arrangement. They are found between the blood vessels and ducts and are oriented at right angles to these structures. This characteristic appears to be restricted to the rat and was not observed in any of the other species studied.

Type III, Perivascular Cells (Lubarsch Cells). These cells are found closely applied to the external surface of the capillaries, as shown in Figure 4A. They are characterized by oval nuclei and have less cytoplasm than other interstitial cell types. Their numerous long and thin or short and thick cytoplasmic processes not only embrace the blood vessels, but reach out to contact other interstitial cells (Types II and IV) or neighboring perivascular cells as well (Figure 6). Within the capillary network perivascular cells may be found at all levels of the renal substance and in both the arterial and venous sectors. However, it appears that they are more abundant in the venous sector. These cells, most commonly termed "smooth muscle cells,"[16] "adventitial cells,"[17] or

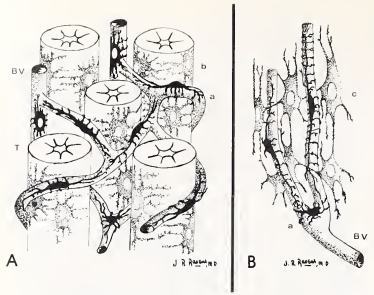


Figure 6—Histodiagrams illustrating the orientation of the perivascular cells: **A:** capillary network (B.V.) showing different aspects of the perivascular cells (a); T: renal tubules with peritubular cells (b); **B:** segment of capillary-blood vessel (B.V.) showing perivascular cells (a) along its longitudinal axis and at the bifurcation, and (c) true interstitial cells.

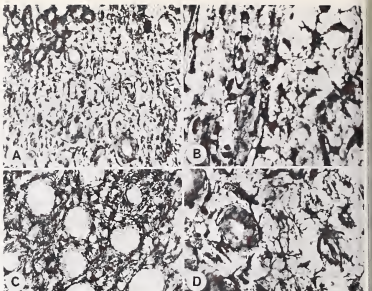


Figure 7—Photomicrographs of the true interstitial cells (Type IV): **A:** Rat kidney; **B:** Cow kidney, to show the distribution of these cells between the tubules (ammoniated silver nitrate impregnation); **C:** Guinea pig kidney; and **D:** Cow kidney, demonstrating the anastomotic tendency of these cells (silver sulphate and ammoniated silver nitrate impregnations).

"pericytes"[18] primarily are oriented along the longitudinal axis of the blood vessels, but also are found frequently at the bifurcations, as shown in Figures 4B and 6.

Type IV, True Interstitial Cells (Vimtrump Cells). Whereas these cells are found throughout the interstitium of the kidney, they are most prominent at the apex of the pyramids, as seen in Figure 7. Here they frequently display a stellate shape with thick, branching cytoplasmic extensions which either anastomose with the processes or are in contact with the body of neighboring cells. In addition to this contact via cytoplasmic extensions, close association of two cell bodies has been observed. In the less densely populated outer medulla and cortex, the true interstitial cells appear to be elongate and flattened and have short cytoplasmic processes.

The primary characteristic distinguishing these cells from the other interstitial cells of the kidney is the absence of any interconnection or association with either renal tubules or capillaries.

DISCUSSION

Until recently, research has provided relatively little information concerning the interstitial cells of the kidney. However, careful investigation of this real component surely will contribute to a greater understanding of the anatomy and physiology of the kidney.

Morphology. Many investigations have contended that the interstitial cells are fibroblasts. Others, however, argue that they are a special type of mesenchymal cell. Given these conflicting points of view, it is reasonable to conclude that we are dealing with a special cell type, which upon differentiation, can acquire secretory, transportive, supportive, and immunologic activity.

Studies of the kidney of laboratory animals and humans, in both experimental and pathologic conditions, have demonstrated that hypertrophy and hyperplasia of the interstitial cells are associated with proliferative or degenerative phenomena.[13,19-21] During the course of these same investigations transformation of interstitial cells to histiocytes and active macrophages or Gitter-zellen also was noted. Von Mollendorff reported the transformation of connective tissue cells into histiocytes and active phagocytes under experimental conditions.[22-23] In vitro studies by Fischer[24] and Parker[25] and work in tissue culture by Weiss[26] have provided similar results. On the basis of these findings (including those from the present study) we strongly believe that these cells are quite similar to the mesenchymal, fibroblast-like, or reticuloendothelial cells which exist in other organs.

These findings can be interpreted to mean that fibroblasts, the cellular component of the connective tissue of some organs, potentially are undifferentiated cells and are capable of undergoing transformation into macrophages in response to various stimuli.

Function. It is likely that interstitial cells have a variety of functions, since they are associated with the glomeruli, tubules, or capillaries, or are found free in the interstitium.

The periglomerular cells primarily compose the supportive frame of the glomerulus and play an important role in reaction to injury in this section of the nephron.

It seems likely that the peritubular cells, which are interposed between the blood vessels and tubules, play an important role in the transport phenomenon. This may be accomplished in two ways, either from tubules to interstitial cells to blood, or via the reverse route. In the former case, the interstitial cells serve to transfer substances from tubules to blood vessels and in the latter they serve to transfer substances from blood vessels to tubules (Figure 8). The presence of microvesicles throughout the cytoplasm of the interstitial cells supports the notion that they are involved in transport. Furthermore, because there are no anatomic connections between renal tubules and capillaries, these peritubular cells seemingly provide the only bridge between them. The findings of this study support the conclusion that there exists in the renal substance a well-defined, anatomic, and functional system of association—"the angio-histio-epithelial unit"—in which the interstitial cells play a very important role.

The perivascular cells truly are pericytes, and as such they participate in both support and defense mechanisms. These cells are capable of reacting to exogenous and endogenous stimuli by differentiation, as pointed out by Ravens.[27] The diffuse distribution and selective localization of the true interstitial cells at the level of the papilla suggests that these

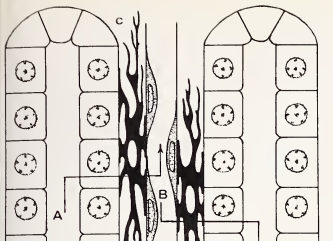


Figure 8—Schematic representation of the *angio-histio-epithelial unit* and its functional concept. A and B indicate the directions of the transport mechanism; T, renal tubules; C: interstitial cells; B.V., blood vessels.

cells also play a role in supportive and reactive phenomena.

Novikoff[28] and Moffat[29] reported that the perivascular cells, which are characterized by a contractile nature, may act on the vasa recta and thereby change the rate of medullary blood flow. Along these same lines Sternberg et al.[12] contend that the peritubular cells have contractile properties and speculate that they play a role in the regulation of urinary volume. Bugler, Griffith, and Trump[30] argue that the peritubular cells may play a role in the concentration of urine.

On a functional basis, the work of Ribbert,[31] Kraft,[32] Teploff,[33] Cappel,[34] Wyburn-Mason,[35] Moffat,[36] Morrison and Schneerberger-Keeley,[37] and others indicate that the interstitial cells are capable of absorbing into their cytoplasm by pinocytosis, such administered substances as lithium carmine dye, acid vital, and intravitam stains, silver nitrate, and ferritin. The work of these investigators has indicated the existence of a route for administered substances to be transported from blood vessels or tubules to the interstitial cells of the kidney.

SUMMARY

In the present study the distribution and arrangement of cells was examined thoroughly at different levels of the renal cortex and medulla. Details of the morphology of these cells were analyzed and the findings provide conclusive evidence that the interstitial cells exist as an integral cellular component, which represents the reticuloendothelial system of the kidney. An attempt has been made to interpret the role that these cells play in renal function.

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REVIEW ARTICLE

SLE: Use of Laboratory Tests in Diagnosis and Management

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PHOEBE R. KREY, M.D., Newark*

The numbers of antinuclear antibodies have been increasing steadily and their specificities in terms of disease states and activity have become very complicated. Antinuclear antibodies, the "LE prep," complement components, immune complexes, and the lupus band test have been reviewed with regard to the diagnosis and management of SLE patients.

Systemic lupus erythematosus (SLE) is a multisystem disease of unknown etiology characterized by a variable and unpredictable course. A hallmark of the disease is the presence of B lymphocyte hyperreactivity as manifested by hypergammaglobulinemia and a myriad of autoantibodies directed against several nuclear, cytoplasmic, and cell membrane constituents. Presently, it is believed that some of the clinical manifestations of SLE result from the deposition of antigen-autoantibody immune complexes, followed by activation of the classical complement cascade and attraction of phagocytic and cytotoxic cells, leading to tissue destruction.[1]

Originally felt to be a rare and fulminant illness whose diagnosis relied exclusively upon characteristic clinical and pathologic (frequently postmortem) findings, it is known now that many mild cases exist and that the prevalence of SLE is 1:600 in white women and as high as 1:250 in black women.[2] Historically, the diagnosis of SLE was facilitated by the LE cell phenomenon and later by the inclusion of the LE preparation within the diagnostic criteria set forth by the American Rheumatism Association in 1971.[3] In the past ten years, the introduction of more sensitive and specific serologic tests has made an earlier and more accurate diagnosis of SLE possible. Some of these tests recently have been incorporated with the 1982 revised criteria for classification of SLE (Table 1).[4]

Analysis of survival data in SLE has revealed an almost linear improvement since 1938.[5] This trend partly is a result of the inclusion of patients with milder forms of SLE who would not have been diagnosed prior to the era of serologic testing. Although unproved, this trend in increased survival also may reflect better therapy, guided by newer, more sensitive laboratory parameters of disease activity.

This article will attempt to clarify generally available serologic tests used in the diagnosis of SLE and to discuss the rationale, usefulness, and limitations of tests currently used to assess disease activity and guide therapy.

THE LE PREPARATION

The observation of LE cells in bone marrow specimens of patients with SLE by Hargraves in 1948 marked the beginning of immunodiagnosis in this disorder.[6] The LE cell (Figure 1) represents a homogeneously stained, pink or purple cytoplasmic inclusion, usually within a polymorphonuclear leukocyte whose own nuclei are pushed to the periphery of the cell. This in vitro phenomenon results from the interaction of 7s IgG antibody (the LE cell factor) in the patient's plasma with deoxyribonucleoprotein (a DNA-histone complex) of nuclei expelled from damaged cells. Binding of this antinuclear antibody to its specific antigen leads to activation of the classical complement pathway and the attraction of viable polymorphonuclear (PMN) leukocytes that attempt to phagocytize the opsonized nucleus. This group of cells surrounding the basophilic immune complex is known as a rosette; final phagocytosis of

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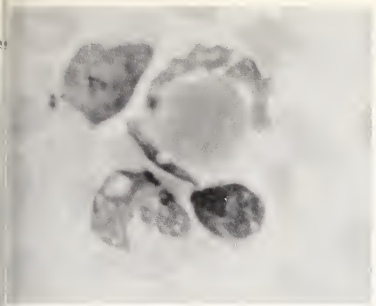


Figure 1—The appearance of the classic LE cell. The velvety, homogeneous inclusion represents an immune complex of deoxyribonucleoprotein and its antibody.

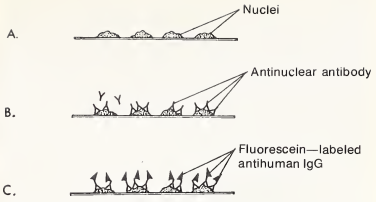


Figure 2—Detection of antinuclear antibodies by indirect immunofluorescence. **A:** Mammalian tissue with exposed nuclei is fixed to a microscope slide; **B:** Slide is incubated with patient's serum and then washed; and **C:** Fluorescein—labeled, antihuman IgG is placed on slide and preparation incubated and washed. Nuclear staining observed under fluorescent light microscope indicates that patient's serum contained antinuclear antibodies.

the immune complex by one of these PMNs results in the classic LE cell. Usually two or more cells have to be seen on a smear for the preparation to be called positive.

LE cells can be prepared from the plasma of 70 to 90 percent of patients with SLE at some time during the course of their disease and in 100 percent of patients with drug-induced SLE (vida infra). LE cells also are seen in up to 10 percent of patients with rheumatoid arthritis and in occasional patients with scleroderma.[8] The presence of LE cells in these disorders usually does not lead to diagnostic confusion. Although its specificity for SLE may be as low as 80 percent,[7] the LE prep remains an extremely useful, albeit now performed infrequently, diagnostic test for systemic lupus. The alert and ambitious house officer still can confirm a diagnosis of SLE on the evening of admission by observing LE cells on a Wright's stain preparation of the buffy coat of peripheral blood that has been incubated for 30 to 60 minutes. LE cells also may be seen in stained preparation of pleural, pericardial, or synovial fluids from patients with SLE and should be sought under appropriate clinical situations.[9,10] LE cells observed in these body fluids represent in vitro immune complex formation and are highly specific for SLE.

The routine LE prep done from patients' sera has many disadvantages. False positives occur when simple nucleophagocytosis is misinterpreted as an LE cell. False negatives occur in patients who have no antibody to deoxynucleoprotein but a variety of other antinuclear antibodies. Also, since many patients with active SLE have leukopenia, another source of phagocytes has to be sought. Above all, the test is time-consuming to perform.

THE FLUORESCENT ANTINUCLEAR ANTIBODY TEST (FANA)

The "LE prep" now is performed rarely, having been largely supplanted by the more sensitive and more standardized technique of indirect immunofluorescence for detecting antinuclear antibodies (ANA or FANA). In this test (Figure 2), a slide fixed with mammalian tissue with exposed nuclei as substrate is incubated with the patient's serum and then washed. If the test serum contains IgG antibodies reactive with nuclear antigens, they are detected under the fluorescent light microscope after incubation of the slide with fluorescein-conjugated antihuman IgG.

In interpreting results of a positive FANA, the dilution of serum must be considered. As many as 20 percent of undiluted sera from healthy controls will be positive, but this figure drops to about 10 percent if only a 1:10 dilution of serum is used. Sera from patients with a variety of acute and chronic medical conditions will be found to contain antinuclear antibodies in low titer to an even greater extent.[11] The ANA becomes more specific for collagen vascular disease as the titer increases above a 1:80 or greater dilution.

Depending on the specificities of antinuclear antibodies in the test serum, four distinct patterns of immunofluorescence may be observed: peripheral (also referred to as rim or shaggy), diffuse (or homogeneous), speckled, and nucleolar. The relationship between antibody specificity and patterns of immunofluorescence is outlined in Table 2. Sera from SLE patients may produce any of the above patterns in the FANA. Since the presence of multiple antinuclear antibodies is a hallmark of SLE,[12] it is not unusual for different patterns to be expressed at different dilutions of serum.

The pattern of ANA positivity is of limited value in discriminating SLE from other collagen-vascular diseases. For example, the peripheral pattern, usually produced by antibodies to native DNA, would be expected to be specific for SLE (vida infra), but also may result for antibodies to deoxynucleoprotein, frequently found in other rheumatic diseases.[7] The speckled pattern of immunofluorescence best illustrates the diagnostic limitations of the FANA. The speckled pattern is produced by antibodies to a variety of acidic (nonhistone) proteins that readily can be extracted from cell nuclei. Using techniques of immunodiffusion, complement fixation, and hemagglutination, it has been shown that antibodies to an ever-growing number of these extractable nuclear antigens (ENAs) appear to be specific for particular rheumatic disease syndromes. Therefore, it is somewhat paradoxical that in the routine ANA test a whole group of antigen-antibody systems with high disease specificity result in a speckled pattern, which generally is the least specific and has been said to account for the largest number of false positive results found in patients without rheumatic disease.[11]

The FANA is the most sensitive laboratory test available for detecting SLE, being positive in up to 95 percent of patients with the disease. The specificity of a positive FANA for SLE, on the other hand, probably is as low as 50 percent

TABLE 1

*Criteria for Classification of SLE**

1. Malar rash
2. Discoid lupus
3. Photosensitivity
4. Oral/nasopharyngeal ulcers
5. Arthritis
6. Proteinuria (> 0.5 gm/day) or cellular casts
7. Seizures or psychosis
8. Pleuritis or pericarditis
9. Cytopenia
   - Autoimmune hemolytic anemia
   - Neutropenia
   - Lymphopenia
   - Thrombocytopenia
10. Anti-nDNA antibodies
    Anti-Sm antibodies
    LE cells
    Chronic false positive VDRL
11. Positive FANA

*American Rheumatism Association, 1982

when applied to patients with rheumatic disease in general.[13] Whereas a negative ANA in a patient with active multisystem disease is relatively strong (but not absolute), evidence against a diagnosis of SLE, a positive ANA in the absence of other clearly defined clinical manifestations of the disease (Table 1), is not diagnostic of SLE.

It is precisely the patient in whom adequate clinical criteria for diagnosing SLE are lacking (i.e. the young woman with arthralgias and Raynaud's phenomenon or the patient with isolated nephrotic syndrome) that more specific diagnostic tests would be most desirable.

ANTIBODIES TO EXTRACTABLE NUCLEAR ANTIGEN (ENA)

Antibodies to ENAs produce a speckled FANA. As mentioned earlier, extractable nuclear antigens (ENAs) are acidic (nonhistone) macromolecules extracted from the saline soluble fraction of cell nuclei. Using calf thymus as a source of nuclear material, at least 11 different antigens have been identified immunochemically to react with sera of patients with different rheumatic diseases.[14] Highly specific antigen-antibody systems now have been identified in patients with SLE, scleroderma, and polymyositis using calf thymus and other cell lines as sources of nuclear material. Complete characterization of ENAs requires immunodiffusion or counter-immunoelectrophoresis using standard reference sera, techniques generally not available to the practicing clinician.

Several commercial laboratories now perform anti-ENAs using a passive hemagglutination assay. This test, which depends upon the ability of the patient's serum to agglutinate tanned sheep red cells that have been sensitized with the saline extract of calf thymus nuclei, detects the presence of antibodies to only two ENAs: RNP (ribonucleoprotein) and Sm (named after a patient with SLE named Smith). Antibodies to RNP are found in 25 to 30 percent of patients with SLE, 10 percent of patients with rheumatoid arthritis, 22 percent of patients with scleroderma, and 100 percent patients with mixed connective tissue disease.[12] Although their occurrence in SLE is associated with milder disease, antibodies are not specific enough to be valuable diagnostically.

Antibodies to Sm antigen, originally described in 1966,[15] are found in the sera of 25 to 30 percent of patients with SLE. Anti-Sm antibody is highly specific and, in fact, presently is considered the most specific diagnostic test for SLE.[13] (Antibodies to MA, detected by immunodiffusion, recently have been described as another highly specific antibody and appear to correlate with severe renal disease.[16])

ANTI-DNA ANTIBODIES

Antibodies reactive with native, double-stranded DNA (anti-DNA) are found in up to 40 to 80 percent of patients with SLE, especially those with active disease. Several studies have confirmed that significant titers of antinative DNA antibodies rarely are found in diseases other than SLE[12,1] and, therefore, almost have as much specificity for SLE as anti-Sm antibodies. Several assays for anti-DNA antibodies are available, but the two most commonly used by commercial and hospital laboratories are the Farr immunoprecipitation technique and indirect immunofluorescence using the hemoflagellate *Crithidia luciliae* as tissue substrate.

In the Farr technique, the patient's serum is incubated with radiolabeled DNA and then precipitated with saturated ammonium sulfate (which will precipitate immune complexes and, therefore, DNA-anti-DNA complexes out of the fluid phase). The percent DNA binding present in the patient's serum can be calculated. The Farr technique is sensitive but potentially nonspecific due to inevitable contamination with single-stranded DNA and due to substances other than anti-DNA antibodies that may bind to nDNA.[17] Thus, whereas greater than 40 percent DNA binding activity is quite specific for SLE, up to 4 percent of normal controls and up to 50 percent of rheumatic disease control groups may show lesser degrees of DNA binding as measured by the Farr or other immunoprecipitation techniques.[11]

The nonspecificity inherent in the Farr technique has been circumvented with the introduction of the *Crithidia luciliae* immunofluorescent technique.[18] This trypanosome contains an organelle, a kinetoplast, that consists of circular native-DNA. Thus, this method circumvents the problem of cross reactivity with single-stranded DNA. When *Crithidia* is used as tissue substrate in the indirect immunofluorescent technique (as described earlier for detection of antinuclear antibodies), positive immunofluorescence specifically identifies anti-nDNA antibodies in the patient's serum. This technique is at least as sensitive as the Farr technique and appears to be the method of choice for detecting anti-nDNA antibodies.

THE LUPUS BAND TEST

Deposition of immunoglobulins with or without complement components at the dermal-epidermal junction occurs in up to 95 percent of lesional skin in SLE or discoid lupus erythematosus. Similar immunofluorescence in clinically and histologically normal skin originally was observed in patients with SLE in 1964, [19] an observation that has been confirmed several times. The lupus band test (LBT) refers to the use of direct immunofluorescence on biopsies of normal skin in patients suspected of having SLE. The LBT is positive in about 50 percent of all patients; this figure approaches 80 percent in patients with active multisystem disease, particularly with active renal involvement.[20,21] Despite reports of positive tests in patients with various malignant and infectious diseases,[22] positive dermal-epidermal staining is extremely rare in other rheumatic diseases. Thus, the test appears to be specific for SLE, especially when IgG is the major immunoglobulin deposited.

The lupus band test is useful diagnostically in patients who lack sufficient clinical manifestations. This especially may be

true in patients whose disease is limited to one major organ system (i.e. renal or CNS). In addition, since this LBT may remain positive for weeks or months after clinical remission or ANA conversion to negative-induced by steroids, the test may be useful for confirming the diagnosis in previously treated cases.[23]

DRUG-INDUCED SLE

The subject of drug-induced SLE recently has been reviewed extensively.[24] Occasionally, the clinician is confronted with a patient with clinical manifestations of SLE who has been taking a drug known to produce an SLE syndrome. Since some of these medications (procainamide, hydralazine, phenytoin sodium) may be lifesaving, it obviously would be undesirable to discontinue a drug that is not involved in producing the symptoms. Recent work has shown that, in the case of procainamide, antinuclear antibodies are directed against histone determinants of the DNA-histone complex. Hydralazine also appears to induce antihistone antibodies, but of different specificity from procainamide.[25] Further developments in this field may allow a confident distinction between idiopathic and drug-induced SLE in complicated situations.

ANA-NEGATIVE SLE

The previous discussion has stressed the importance of detecting antinuclear antibodies in making a diagnosis of SLE. One must be cautioned, however, against overreliance upon the presence of a positive ANA in making the diagnosis of SLE. Approximately 5 percent of patients with clinically diagnosable SLE have persistently negative ANAs.[26] Some of these patients have a congenital deficiency of an early complement component (most commonly C4 or C2), detected by absent total hemolytic complement (CH50) activity in serum.[27] Other patients have been found to have serum antibodies that react to cytoplasmic antigens rather than nuclear antigens.[28] These groups of ANA-negative patients tend to have prominent cutaneous disease and a low incidence of serious renal and neuropsychiatric disease.

Finally, detectable antinuclear antibodies may disappear from the sera of patients who previously were positive and whose disease has entered remission. Thus, a negative FANA should not be used to exclude a diagnosis of SLE.

LABORATORY ABNORMALITIES AS GUIDE TO THERAPY IN SLE

Once SLE has been diagnosed, one is faced with the formidable task of managing an unpredictable, potentially fatal illness. The appropriate management of overtly active disease depends upon which clinical aspect of SLE is active (i.e. cutaneous, serositis, or renal disease) at a particular point in time. Although indications for antiinflammatory, steroid, and more potent immunosuppressive drugs can be found in standard references,[29] the overall management of SLE is a delicate and controversial affair for which no truly "standard" approach is available. One of the major controversies in the management of SLE involves the use of laboratory parameters of disease activity to guide therapy.

Listed in Table 3 are two arbitrary groups of laboratory parameters that typically are followed in lupus patients—"traditional" and "current."

Using the traditional laboratory parameters, the patient with active SLE generally will be anemic. The simple hemoglobin measurement correlates very well with disease activity and is certainly among the easiest and cheapest parameters to follow. Anemia in SLE most commonly is the anemia of chronic disease, autoimmune hemolytic anemia, occurring in no more than 2 percent of patients.[30] The ESR typically (but not invariably) reflects active disease as well.

"The FANA is the most sensitive laboratory test available for detecting SLE, being positive in up to 95 percent of patients with the disease."

Leukopenia (WBC < 4,000) and, in particular, lymphocytopenia (< 1500) may reflect active disease in many patients. Of interest, lymphocytopenia strongly is correlated with the presence of lymphocytotoxic antibodies and, thus, may reflect humorally mediated depletion of suppressor T lymphocytes.[31] Although generally not appreciated, marked leukocytosis (> 25,000) may occasionally be manifestation of active SLE.[32]

Microscopic hematuria, pyuria, red cell casts, and proteinuria reflect active renal involvement in SLE. The level of proteinuria and, more importantly, elevations of the serum creatinine are important prognostic indicators in renal disease, although they necessarily do not correlate with active renal disease as determined by renal biopsy.

All of these traditional parameters have stood the test of time as mirrors of overall disease activity in SLE and have proved useful in guiding therapy of established flares. Changes in these parameters in the asymptomatic patient should lead to closer monitoring for a possible disease flare. These traditional laboratory parameters, however, are relatively nonspecific (they do not help distinguish active SLE from superimposed infection or drug-induced nephrotoxicity) and may not be sensitive enough to detect early, treatable disease exacerbations.

It is here that the current laboratory parameters of disease activity have attracted much recent interest, along with considerable controversy. As outlined earlier, several manifestations of SLE probably are mediated by the deposition of circulating immune complexes (in particular DNA-anti-DNA complexes) with activation of the classical complement system and subsequent elaboration of mediators of inflam-

TABLE 2

Relation Between Nuclear Antigens and Patterns of ANA Fluorescence

Antigen	Pattern
DNA, DNA-histone	Peripheral
ENA (RNP, Sm)	Speckled
Deoxyribonucleoprotein (DNA-histone)	Diffuse
RNA	Nucleolar

TABLE 3

Laboratory Parameters of Disease Activity in SLE

Traditional	Current
Hemoglobin	C3, C4 levels
WBC	Anti-DNA levels
Urinalysis	Immune complexes
Creatinine	
Erythrocyte sedimentation rate	

mation and tissue destruction. As a result, active disease frequently is accompanied or preceded by a decrease in measurable early complement components,[33] increasing titers of anti-DNA antibodies,[34] and the appearance of circulating immune complexes demonstrable by a variety of assays.[35] Likewise, disease remissions, either spontaneous or induced by treatment, commonly are accompanied by normalization of these three measurements.

COMPLEMENT IN SLE

Activation of the complement system in SLE occurs via the classical pathway (recognition of immune complexes by Clq, activation of C4 and C2, cleavage of C3, and generation of the membranolytic components C6 to C9). In clinical practice, two different measurements of complement consumption are available widely. In the total hemolytic complement assay (CH50) the integrity of the entire classical pathway is measured by the ability of the patient's serum to induce lysis of antibody-sensitized sheep erythrocytes. The availability of specific antibodies to individual complement components also has allowed measurement of C3 and C4 by radial immunodiffusion. Of available tests, it has been demonstrated that determination of the C4 level is the most sensitive test reflecting active disease, particularly active nephritis. In addition, clinical improvement most reliably is reflected by the level of C4 in serum.[33]

CIRCULATING IMMUNE COMPLEXES

A variety of immunologic techniques are available for detection of immune complexes. Those most commonly applied to the study of SLE include Clq binding (which presumably measures immune complexes capable of fixing complement), the monoclonal rheumatoid factor assay (detecting the Fc portion of complexed IgG), and the Raji cell assay (which is felt to recognize immune complexes containing C3b). The usefulness and limitations of these and other assays recently have been reviewed extensively.[36] Although not as sensitive as some of the newer immunologic assays, simple incubation of serum at 4° for the detection of cryoglobulins is the most readily available assay for circulating immune complexes and their presence correlates well with disease activity.[37]

Regardless of which technique is employed, it has been shown repeatedly that in SLE the quantity of immune complexes correlates strongly with hypocomplementemia and active disease, particularly active nephritis.[38,39] The presence of immune complexes usually predicts a disease flare, although their value in predicting which organ system will be involved is limited.[35]

ANTI-DNA ANTIBODIES

The diagnostic specificity of anti-DNA antibodies already has been described. Anti-DNA antibodies are considered to be of prime importance in the pathogenesis of lupus nephritis. However, several studies have failed to demonstrate a good correlation between anti-DNA levels and disease activity (extra-renal or renal).[39,40] It appears, then, that anti-DNA antibody levels are not as useful a parameter to follow as are C4 levels or levels of circulating immune complexes.

In large series of patients with SLE, it would appear that flares of disease may be predicted and avoided by early therapy if C4 levels suddenly fall and immune complex levels and (to a lesser extent) anti-DNA levels rise. However, as applied to an individual patient with SLE, the clinical status of the patient always must be correlated with changes in these laboratory parameters for proper diagnostic and treatment decisions to be made.

The strongest correlation between these parameters and disease activity applies to active nephritis, but even in this situation from 10 to 25 percent of patients may exhibit flares of renal disease with normal complement levels, negative anti-DNAs and absence of detectable circulating immune complexes.[40] Also, complement, anti-DNA, or immune complex profiles cannot substitute for a renal biopsy in determining the histological class of lupus nephritis in a given patient.[41]

Abnormalities in these tests do not predict reliably which manifestations of SLE are likely to become active.[35,40] In addition, the time interval from the development of laboratory abnormalities to actual disease flare is highly variable, ranging from weeks to several months.[40] At the far extreme are those patients with SLE who never manifest active disease despite striking abnormalities in these laboratory parameters.[40,42]

When effective, nontoxic therapy for serious complications of SLE becomes available, then early treatment in anticipation of complications, based solely on changing laboratory parameters, may be rational. With the presently available therapy (i.e. corticosteroids and immunosuppressives), such a policy is controversial at best. Thus, when complement, anti-DNA, or immune complex levels become abnormal, the patient should be observed more closely. In the patient who has demonstrated that life-threatening flares of disease predictably are preceded by laboratory aberrations, then early and aggressive therapy may be indicated on the basis of laboratory data alone. Finally, since C4 and immune complex levels parallel disease remissions, these parameters may be useful to follow while tapering therapy. Whether the "newer" parameters necessarily are more useful than some of the "traditional" parameters (vida supra) has not been established clearly.

SUMMARY

Systemic lupus is a disease that should not be diagnosed in the absence of compatible clinical findings. Nonetheless, several immunologic tests now are available as aids to the early and precise diagnosis of this variable, multisystem illness.

Although less specific for SLE than LE cells, the FANA is the most sensitive test for detecting SLE, and now is the screening procedure of choice. At the present time the most specific marker for SLE is the presence of antibodies to an acidic, nonhistone nuclear antigen called Sm. These antibodies are present in only 25 to 30 percent of patients with SLE. Antibodies to native DNA are almost as specific for SLE as are antibodies to Sm and are detected in at least 50 percent of patients. The finding of deposits of immunoglobulins at the dermal-epidermal junction of normal skin is relatively specific for SLE and diagnostically may be useful in certain situations.

The management of SLE may be facilitated by the judicious use of several laboratory parameters of disease activity. The level of C4 in serum is inversely correlated with disease activity and is the most useful parameter of disease activity to follow. This particularly is true with respect to nephritis. The detection of high levels of circulating immune complexes, especially when associated with low C4 levels, usually indicates active disease as well. Levels of anti-DNA antibodies do not parallel disease activity reliably enough to make them

useful in planning treatment.

Stable patients who demonstrate hypocomplementemia and/or high levels of circulating immune complexes should be followed closely for disease flares. Whether they should be treated solely on the basis of laboratory abnormalities is an unanswered question and depends for the most part upon previous experience in an individual patient.

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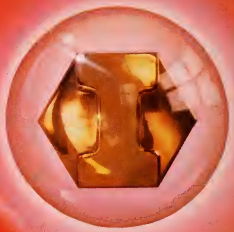
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BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psycholtropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure Propranolol acts selectively without aboishing the inotropic action of digitalis on the heart muscle (i e , that of supporting the strength of myocardial contractions) In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect The effects of propranolol and digitalis are additive in depressing AV conduction

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure In rare instances, this has been observed during propranolol therapy Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of propranolol therapy Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised Special consideration should be given to propranolol's potential for aggravating congestive heart failure Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm This is another reason for withdrawing propranolol slowly Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e g , isoproterenol or levarterenol However, such patients may be subject to protracted severe hypotension Difficulty in restarting and maintaining the heart beat has also been reported

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e g , CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia This is especially important to keep in mind in patients with labile diabetes Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure

USE IN PREGNANCY The safe use of propranolol in human pregnancy has not been established Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered The added catecholamine-blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals The drug should be used with caution in patients with impaired renal or hepatic function

ADVERSE REACTIONS

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura *Central Nervous System* lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis *Allergic* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress *Respiratory* bronchospasm *Hematologic* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura *Miscellaneous* reversible alopecia Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol *Clinical Laboratory Test Findings* Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

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Hypoperfusion and Absent Ventilation to the Lung from Mucous Obstruction

JOHN V. CHOLANKERIL, M.D., CARLOS REMOLINA, M.D., KASTORIL GOPINATHAN, M.D., ROBERT CARDUCCI, M.D., Elizabeth*

A chronically ill patient developed respiratory failure, diminished ventilation, and hypoperfusion to the left lung. Bronchoscopy revealed large amounts of secretions in the left main stem bronchus. After removal of the secretions, the ventilation and perfusion scans reverted to normal. Our case reaffirms that reflex hypoperfusion of the entire lung may be secondary to mucous obstruction of the bronchus.

Absent perfusion or hypoperfusion to an entire lung has multiple causes: extrinsic compression of the pulmonary artery, pulmonary embolism, developmental abnormalities, parenchymal lung disease, endobronchial obstruction, and postoperative abnormalities.[1-7]

CASE HISTORY

The patient was a completely bedridden 55-year-old male with multiple medical problems. He was hospitalized with a febrile illness. On the third day the patient developed an acute shortness of breath. Physical examination showed a white male in moderate respiratory distress with blood pressure 120/70, pulse 90, and a respiratory rate of 26. Rales and rhonchi were heard over both lung bases.

Laboratory data showed: pH 7.55, PCO_2 34, and PO_2 79 with a widened alveolar-arterial oxygen gradient. The hemogram showed a white cell count of 12,000, hemoglobin 11.7, and hematocrit 36. The SMA appeared to be within normal limits with the exception of an elevated alkaline phosphatase. The chest x-ray showed no active infiltrates in the lungs. The heart was enlarged slightly and the pulmonary vasculature was normal.

The possibility of pulmonary embolism was considered, and ventilation and perfusion scans were performed. The perfusion scan showed hypoperfusion to the entire left lung (Figure 1). The ventilation scan showed absent ventilation to the left lung (Figure 2). A CT scan done within the next few hours revealed the main bronchi, mediastinum, and pulmonary vasculature to be normal. Tomogram of the mediastinum showed no endobronchial masses (Figure 3). Fiberoptic bronchoscopy showed no masses. Large amounts of secretions were found in the left bronchus and these were removed, following which the patient felt much better. A repeat perfusion scan after the removal of the mucous from the left bronchus demonstrated a normal perfusion (Figures 4 and 5). A diagnosis of mucous obstruction of the left bronchus was made. The patient then was treated symptomatically and experienced a rapid improvement of respiratory symptoms.

DISCUSSION

Lung perfusion scanning is an accurate method of determining the relative distribution of pulmonary arterial blood flow. In cases of bronchial obstruction, the hypoperfusion is due to reflex changes. Isawa et al. showed that bronchial obstruction resulted in decreased pulmonary perfusion in dogs. They postulated that hypoperfusion to the lungs is due to alveolar hypoxemia producing reflex vasoconstriction.[8]

Unilateral decreased or absent perfusion is a rare finding. White et al. found this phenomenon in only 2 percent of 607 lung scans studied in one year. A good number of this 2 percent were due to endobronchial obstructions.[3] Some of the causes of endobronchial obstruction causing unilateral hypoperfusion are: endobronchial tumors such as bronchial adenoma and bronchogenic carcinoma; foreign bodies; im-

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Figure 1—Perfusion lung scan shows hypoperfusion to the entire left lung.



Figure 2—Ventilation scan shows absent ventilation to the whole left lung.

properly positioned endotracheal tubes; mucous plug, and bronchiolithiasis.[1-4,10]

Ventilation problems involving an entire lung that are known to cause perfusion abnormality are: (1) post-inflammatory damages to the lung parenchyma (Swyer-James syndrome); (2) active infection; (3) radiation therapy; (4) massive pleural effusion; (5) pneumothorax; (6) pneumonectomy; (7) thoracoplasty; and (8) pleuritic pain.[3-5,9]

Other causes of unilateral perfusion abnormality are: (1) extrinsic compression of the pulmonary artery from nodes or tumor; (2) major pulmonary embolus occluding the central pulmonary artery; (3) congenital abnormalities such as pulmonary artery agenesis, hypoplasia, and unilateral



Figure 3—Tomogram of the left mediastinum shows no abnormalities.

pulmonary vein atresia; (4) congenital heart disease after shunting procedures (e.g. tetralogy of Fallot with subclavian to pulmonary artery stenosis); and (5) pulmonary venoocclusive disease.[3-7]

A normal perfusion scan virtually rules out pulmonary embolism.[11] A properly performed ventilation study will increase the probability of assurance in the diagnosis of pulmonary embolism. The isotope scan findings in the pulmonary embolism include: multiple small areas of perfusion defect or a large area of perfusion defect with normal ventilation and a normal chest x-ray; and a perfusion defect that is larger than an associated pulmonary infiltration.

In our patient there was marked decrease in perfusion to an entire lung with absent ventilation; this is not the finding in pulmonary embolism. However, occasionally in acute massive pulmonary embolism, one may get ventilation defects due to bronchial spasm.

Cholankeril et al.[11] and Godwin et al.[12] showed that major proximal and central pulmonary emboli can be well demonstrated by computed tomography (CT). These proximal major emboli appear as filling defects in the proximal pulmonary artery. Small, distal emboli are difficult to demonstrate by CT scanning.[11,12] The amount of hypoperfusion seen in our case may be explained only by a central or proximal pulmonary emboli, if it is due to embolism. CT scan showed normal proximal vessels in our case and thus ruled out a hypoperfusion caused by a major emboli.[11,12]

Our patient complained of acute shortness of breath; his radionuclide scans showed hypoperfusion and absent ventilation of the left lung. CT scan mitigated against major pulmonary emboli.[11-13] Bronchoscopy revealed a large



Figure 4—Repeat perfusion scan shows normal perfusion to the left lung.



Figure 5—Repeat ventilation scan shows normal ventilation to the left lung.

amount of thick mucous that was removed, following which the patient experienced symptomatic relief. A repeat scan immediately after bronchoscopy (within 36 hours of onset of symptoms) showed normal perfusion and ventilation on the left side. Makler et al. reported a case of unilateral hypoperfusion of one lung in 1977.[4] They did not do bronchoscopy or a ventilation scan. A repeat scan in their case, after pulmonary drainage, showed normal perfusion and they assumed this case to be due to a mucous plug. In our case, not only was a ventilation scan performed, but the cause was proved to be thick mucous obstructing the left bronchus by bronchoscopy.

SUMMARY

We describe a case of reflex hypoperfusion to the left lung secondary to obstruction of the bronchus by thick mucous secretions. In such cases, hypoperfusion is due to reflex vasoconstriction from alveolar hypoxemia caused by bronchial obstruction. After bronchoscopic removal of the thick mucous, the pulmonary perfusion scan became normal. A differential diagnosis in a unilateral hypoperfusion or absent perfusion also is discussed.

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Potentiated Anaphylaxis to Allergenic Extracts with Pharmacologic Beta-Adrenergic Blockage

M.H. AMIR ZANJANIAN, M.D., Passaic*

The use of propranolol and other beta-adrenergic antagonists has increased during recent years. Physicians who treat patients suffering from bronchial asthma and allergic rhinitis should be aware of the life-threatening anaphylactic reactions in those individuals receiving immunotherapy.

The use of beta-adrenergic antagonists in the treatment of cardiovascular diseases has increased in recent years. Propranolol, in particular, is administered to control hypertension, paroxysmal atrial tachycardia, angina pectoris, and certain other types of cardiac arrhythmias. This beta-adrenergic blockade is not cardioselective, but also acts on the beta receptors in bronchial smooth muscles to increase airway resistance. As indications to prescribe these drugs increase, adverse effects have become more frequent.[1] Among these side effects, we emphasize anaphylactic reactions in the allergic individuals receiving immunotherapy.

CASE REPORT

Our patient, a 49-year-old black female, had been receiving immunotherapy for many years for treatment of allergic rhinitis and bronchial asthma, but never experienced any systemic reactions from the injections. On June 17, 1982, she was given 1,000 protein nitrogen units (PNU) of ragweed and tree pollens in one arm, and 1,000 PNU of grass pollens and 0.1 cc of dust 1-10 in the other arm. She had been injected monthly with the same dosages without any local or systemic reactions. This included the most recent injections she had been given four weeks prior to the above date. Within ten minutes she complained of tightness in the chest and subsequently developed wheezing, hoarseness, and muffled voice indicating laryngeal edema. She was immediately given aqueous epinephrine subcutaneously (0.15 ml of 1:1000) in each injection site. She then complained of severe headaches, and dyspnea became more severe. Her blood pressure rose to 190/120 mm/Hg.

At this time, further treatment was started; this included intravenous fluid, an infusion of aminophylline 250 mg and hydrocortisone 125 mg, and oxygen. Her blood pressure came down to 150/110 in about 30 minutes, and the wheezing improved to some extent. In view of her inadequate response to the emergency treatment, the patient was hospitalized for 48 hours and was given intravenous aminophylline and hydrocortisone.

Upon admission to the hospital, further history revealed that her family physician had prescribed Inderal** for the treatment of hypertension. This drug was discontinued promptly in the hospital and she was discharged after disappearance of her symptoms.

DISCUSSION

Adverse effects of beta-adrenergic antagonists have been described for almost two decades. They are contraindicated in bronchial asthma and allergic rhinitis, at least during the pollen season. They should be used with extreme caution in

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**Propranolol

patients prone to nonallergic bronchospasm, e.g. chronic bronchitis and emphysema, since they may block bronchodilatation produced by endogenous and exogenous catecholamine stimulation of beta receptors. As early as 1967, Reed and Ouellette reported that ragweed hay fever patients previously found to be nonreactive to methacholine bronchial provocation demonstrated increased sensitivity to ragweed aerosol if pretreated with 5 mg of propranolol intravenously 20 minutes prior to challenge.[2] Shereff et al. demonstrated a significant increase in skin reactivity in atopic patients pretreated by iontophoresis of propranolol into the skin-test sites.[3] It also has been demonstrated that mice, which generally are resistant to chemical mediators such as histamine and serotonin, become extremely sensitive to histamine after treatment with propranolol.[4] These pretreated mice became susceptible to passive systemic anaphylaxis. Recently, Jacobs et al. described two patients who had anaphylactic reactions to known allergens after being treated with propranolol.[5]

"Beta-adrenergic antagonists are contraindicated in bronchial asthma and allergic rhinitis, at least during the pollen season."

Our patient differs from the cases reported by Jacobs et al. in various respects. Our patient showed an anaphylactic reaction to the maintenance doses of allergenic extracts whereas one of the Jacob's patients was restarted on injections after a period when her allergy therapy had been discontinued. That patient suffered from allergic rhinitis, while our patient has bronchial asthma and seasonal rhinitis. The second case reported by Jacobs et al. showed systemic reaction to foods while being treated by propranolol. Both cases reported by these authors developed bradycardia associated with hypotension, whereas our patient developed severe hypertension. Her hypertension partially could be explained by severe hypoxemia as the result of laryngeal edema and severe bronchospasm. The mechanism for potentiated anaphylaxis to known allergens in patients pretreated with propranolol appears to be the competitive inhibition of beta-adrenergic receptors.[4,5]

CONCLUSION

Beta-adrenergic antagonists, generally used in the treatment of cardiovascular diseases, decrease heart rate, cardiac output, and blood pressure. However, by the competitive inhibition of beta-adrenergic receptors, these drugs increase patients' sensitivity to specific allergens. Physicians treating atopic patients with immunotherapy should become more aware of the potentiated anaphylaxis. It is appropriate to ask the patients if they have been started on any new drugs by other treating physicians, before each dose of an allergenic extract is administered.

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II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred dunng initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out.

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Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasng left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical tnal has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation ot angina

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

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In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

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COMMENTARY

Potentiated Anaphylaxis to Allergenic Extracts with Pharmacologic Beta-Adrenergic Blockade

ARTHUR A. GOLDFARB, M.D., Teaneck*

The article by M.H. Zanjanian, M.D., is extremely important because of the frequent lack of communication between the patient and the allergist when an allergic patient is placed on drugs by another physician. Propranolol (Inderal®), nadolol (Corgard®), metoprolol (Lopressor®), atenolol (Tenormin®), and timolol (Blocadren®) can prevent the bronchodilatation necessary to counteract anaphylactic shock.

Many patients with heart disease or migraine take large doses of beta-blockers. Occasionally, patients who are allergic clinically seem to tolerate low dose beta-blockers without any obvious untoward effects. Therefore, a detailed history of exact dosage is important.

Once I become aware of a patient's use of propranolol or other beta-blockers, I cut back on the total immunization dosage in an attempt to avoid possible constitutional reactions.

The use of glucagon in the treatment of anaphylaxis due to beta-adrenergic blockade by propranolol recently has been mentioned.[1-3] It is not yet approved for use in human beings, although it was reported as long ago as 11 years. Its use is controversial[4] and there yet is not a large series of controlled patients studied.

For treatment of anaphylactic shock in patients on beta-blockers, intravenous fluids, isoproterenol, and dopamine can be given by continuous infusion. Repeated subcutaneous injections of aqueous 1-1000 epinephrine also may be needed. Corticosteroids take many hours to show an effect, so they should be given intravenously since anaphylactic shock may be prolonged. Corticosteroids increase the cyclic AMP and the number of beta-adrenergic receptors available. Supportive measures and an open airway may be life saving.

Zanjanian's excellent case report should serve as a warning to all who use immunization treatment for allergic patients to obtain a detailed history from each patient on each visit.

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*Dr. Goldfarb is a member of the Editorial Board.

CLINICAL NOTE

Diverticulitis of the Terminal Ileum

JOHN V. CHOLANKERIL, M.D., JUAN A. HERNANDEZ, M.D., RAFEUL HUDA, M.D., MATHEW V. CHOLANKERIL, M.D., Elizabeth*

A 56-year-old woman developed acute abdominal pain with right lower quadrant tenderness and rebound tenderness. She improved after antibiotic therapy. Barium enema study revealed diverticulitis of the terminal ileum with spasm and narrowing. Our patient is unique because a preoperative diagnosis of diverticulitis of the terminal ileum was made. The gross specimen in such a case may not be differentiated easily from neoplasm or regional enteritis.

Acute diverticulitis of the terminal ileum is a very infrequent condition with symptoms that may mimic acute appendicitis.[1,4] Due to this clinical presentation, patients usually are not studied by barium enema and a preoperative diagnosis seldom is established. At surgery, inflammatory masses secondary to diverticulitis may be indistinguishable from neoplasm or regional enteritis.

Diverticula of the small bowel usually are acquired rather than congenital.[2,3] They occur on the mesenteric border of the intestine, usually at sites of vascular penetration of the mesenteric attachment.[2,3] It usually is a "false" diverticulum consisting of a thin-walled sac which contains mucosa, submucosa, and peritoneum. The muscle coats are markedly thinned or absent.[2,3]

CASE HISTORY

A 56-year-old black woman was admitted to Saint Elizabeth Hospital for acute abdominal pain which became localized to the right lower quadrant. The patient was febrile.

The patient had mild hypertension and diet-controlled diabetes mellitus. Five years previously, she had been admitted to Saint Elizabeth Hospital for liver abscess which was drained. During that admission, a barium enema revealed multiple diverticula of the terminal ileum. She had abdominal hysterectomy 10 years ago and umbilical herniorrhaphy 18 years ago, but she did not recall if her appendix was removed during any of this surgery.

Physical examination revealed temperature 101° F, blood pressure 130/80, and pulse 90/min. Abdominal examination elicited right lower quadrant discomfort and slight rebound tenderness. The remainder of the physical examination was unremarkable.

Laboratory data revealed: WBC 8,800 with 66% polys, 7% bands, lymphs 20%, monos 7%, hemoglobin 11.3 gm, hematocrit 33.4%, MCV 86. Three days later, the WBC was 9,300 with 71% polys, 6% bands, lymphs 13%, monos 8%, eos 2%. Electrolytes, serum iron, iron binding capacity, serum B-12, and folate were normal. Blood and urine cultures were negative.

Gallbladder series, radionuclide hepatobiliary studies, intravenous urogram, ultrasound study of the pelvis and upper gastrointestinal series were normal. Barium enema revealed normal large bowel and the terminal ileum showed multiple small diverticula with one area exhibiting mucosal thickening and narrowing due to spasm (Figure 1). Small bowel x-ray series was negative except for multiple diverticula of the terminal ileum with an area of spasm and thickening. No perforation was demonstrated.

CLINICAL COURSE

A diagnosis of diverticulitis of the terminal ileum was made. The patient was treated with antibiotics and improved. Laparotomy, right hemicolectomy, and resection of the terminal ileum were performed 18 days after initial hospitalization. The surgical specimen consisted of a 10 cm

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Figure 1—Barium enema study shows diverticula of the terminal ileum (arrow) with an area of spasm and thickening due to diverticulitis (arrowhead).

segment of ileum and 7 cm segment of cecum and ascending colon. The appendix was absent. A number of small diverticula measuring less than 1 cm in diameter were found throughout the terminal ileum. Several revealed marked induration of the surrounding pericolic fat. An area of hemorrhage was noted on the serosal portion of the midsegment of the resected ileum. Other than some edema surrounding the diverticular openings, the mucosal surfaces appeared unremarkable. Microscopically, a chronically inflamed diverticulum was demonstrated (Figure 2). The process was quite severe and extended to the paradiverticular tissues and the serosal surfaces; focal peritonitis was present. Photomicrography of the paradiverticular area at a higher magnification disclosed to better advantage the nature of the inflammatory infiltrate: microabscesses were demonstrated (Figure 3), but the bulk of the reaction was of a xanthogranulomatous nature incorporating groups of foreign body-type giant cells (Figure 4). This gave indirect evidence of previous diverticular perforation.

DISCUSSION

Several authors report the incidence of mesenteric small bowel diverticula to be from 0.06 to 1.3 percent.[2-6] Contrast x-ray studies have a low sensitivity for this condition.[3,4,6] Diverticula of the duodenum (24 to 44 percent), colon (24 to 53 percent), and hiatus hernia (20 percent) frequently are associated.[2,3,5] Small bowel diverticula usually are multiple and confined to the jejunum. The ileal diverticula seldom are numerous. Diverticula of the jejunum are five times more frequent than diverticula of the ileum.[2,3,5] Most ileal diverticula are found near the ileocecal valve and generally are quite small with a narrow neck similar to colonic diverticula.[2] Jejunal and duodenal diverticula usually are large with a wide neck.[2,5] Diverticula of the ileum are found on the

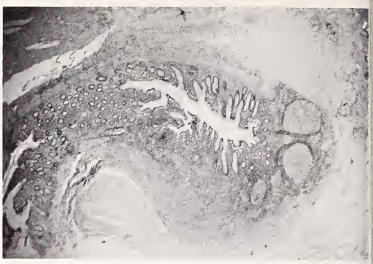


Figure 2—Low power shows a general view of one of the markedly inflamed ileal diverticula.

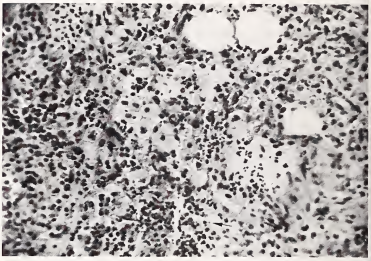


Figure 3—High power demonstrates some of the paradiverticular microabscesses (arrows).

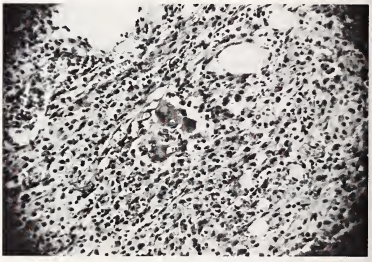


Figure 4—Medium power shows the paradiverticular tissues revealing a chronic xanthogranulomatous inflammatory reaction with foreign body giant cells.

mesenteric border of the ileum. They readily are distinguished from a Meckel's diverticulum, which is solitary, somewhat larger, and arises on the antimesenteric border of the ileum 30 to 90 cm proximal to the ileocecal valve.[2]

There are no characteristic signs or symptoms of diverticulosis of the small bowel. Three clinical situations have been delineated in the literature: 1) They usually are incidental findings and of no apparent clinical significance.[3,5] 2) Some patients have chronic dyspepsia, flatulence, bowel disturbance, or colicky pain. These symptoms usually are due to coexisting conditions like gallbladder disease, peptic ulcer, neoplasm, gynecological problems, or colonic diver-

ticulitis rather than to small bowel diverticulosis.[3,5] 3) Rare patients have right lower quadrant pain, abdominal rigidity, tenderness, and a palpable mass. Usually such patients have a complicated course.

Complications of small bowel diverticula occur in less than 10 percent of cases.[5] Acute diverticulitis may cause peritonitis, localized abscess, adhesions, and acute intestinal obstruction. Other complications include concretion formation and intestinal obstruction, hemorrhage, traumatic rupture, volvulus, macrocytic anemia, fistula formation, neoplasm, and foreign body impaction.[2,3,5]

The inflammatory changes in diverticulitis are the result of irritation or occlusion of the diverticulum by food particles or foreign bodies. Local swelling and edema cause further stasis and the inflammation extends intramurally. Perforation may occur with generalized or localized peritonitis. Peritonitis and inflammation of the mesentery may occur without any significant gross changes in the lining of the involved diverticulum or in the adjacent intestinal mucosa. The inflammatory process may subside resulting in areas of fibrosis causing intestinal stenosis or obstruction.[2] A preoperative diagnosis of appendicitis is to be expected since the inflammatory process is close to the appendix and also developing from the ileum which is embryologically a midgut structure.

Miller and Felson described the features of diverticulitis in contrast studies as an extrinsic mass contiguous with and indenting the small bowel, a local thickening of mucosal folds in the affected segments, and/or perforation, localized, or free.[2]

Clements and Berman reported a patient with an acute surgical right lower quadrant tenderness and guarding.[1] At surgery, they found an inflammatory mass which was indistinguishable from regional enteritis. A subsequent small bowel study showed multiple diverticula of the terminal ileum. Miller and Felson reported a patient who had a five-month history of intermittent right lower quadrant pain.[2] A diagnosis of chronic diverticulitis was made on the basis of barium studies and confirmed at surgery. Lee and Finby reported a patient with rigid right abdomen and bloody diarrhea.[3] At surgery, this was indistinguishable from carcinoma. Histology showed a perforated diverticulum with abscess formation. The patient reported by Bartone and Grieco presented with right lower quadrant pain indistinguishable from appendicitis.[4] At surgery, a mass was found which readily could not be distinguished from neoplasm. Pathology showed diverticulitis of the terminal ileum with perforation. Cocks and Zino reported a case of acute abdomen with signs and symptoms suggesting appendicitis.[5] No barium enema was performed. At surgery, an inflammatory mass of the terminal ileum was found. Histology showed diverticulitis with perforation and localized abscess formation. In their report, Cocks and Zino reviewed eight cases including the cases of Lee and Finby and Miller and Felson. Of those eight cases, seven (except the case of Miller and Felson) had signs and symptoms mimicking acute appendicitis and pathology showed diverticulitis with perforation.[5] Delaney and Hedges reported a case of acute abdomen with diffuse tenderness and right lower quadrant muscle guarding and bloody bowel movement. At surgery, a hemorrhagic mass was seen in the region of the terminal ileum with serosanguinous fluid in the peritoneal cavity. Histology showed a hemorrhagic ileal diverticulum associated with edema and moderate neutrophilic infiltrate.

Our patient presented with fever, right lower quadrant tenderness, and rebound tenderness. She showed improvement on conservative antibiotic treatment. Barium enema and small bowel study showed diverticula of the terminal ileum with an area of mucosal thickening and spasm suggesting diverticulitis. Surgery eventually was performed that showed diverticulitis of the terminal ileum with abscess formation and perforation.

Of the cases we reviewed from the literature, most presented with similar signs and symptoms (mimicking appendicitis).[1-6] Most of the patients had perforated diverticula at surgery (except the cases of Clements and Berman and Miller and Felson). Most of these patients had immediate surgery without barium study due to the severity of the illness. Since our patient showed some improvement on antibiotic therapy, barium studies were performed and a preoperative diagnosis was possible. Of main interest is that our patient was ill with liver abscess five years prior to this admission; this probably was due to perforated diverticulitis. At that time, barium enema showed diverticula of the terminal ileum.

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Confrontation

DAVID I. CANAVAN, M.D., Lawrenceville*

Having identified the impaired physician, our next challenge involves confrontation of the physician with the facts of his or her illness. The term "intervention" is used by some writers to describe the same procedure.

The remarks that follow will fit all of the types of impairment with which we are concerned; however, the majority of our impaired colleagues are substance abusers (85 percent) and so we will focus on this model in describing the techniques used.

In my early years in the field of alcoholism there were two precepts that were accepted as "gospel."

1. "Before the alcoholic can be helped he or she must reach bottom." "Bottom" was a term used to indicate losses of such significance in the life of the victim that they were certain to bring the victim to the ultimate realization that he or she was indeed powerless over alcohol and that alcohol itself, or one's own "alcoholism," was the root cause of all of the problems in life. The level of this "bottom" varied from one victim to another. There were "high bottom," "middle bottom," and "low bottom" alcoholics. Whatever the level, "hitting bottom" was a prerequisite for recovery. Some early cognoscenti reasoned that perhaps you could raise the level of "bottom" in these cases or accelerate the client's arrival at "bottom" in order to hasten intervention.

2. "The alcoholic cannot be helped until he or she is willing to be helped." This takes into account the belief that "hitting bottom" did not necessarily bring along with it acceptance of the obvious cause, nor a willingness to seek out or accept appropriate treatment. Only when the victim was ready to accept help was there any chance of successful intervention. We, the workers in the field, accepted these precepts in blind faith. We sat back and waited for the right moment. In the meantime, our patients got worse and occasionally went on to die, untreated, of these diseases.

Industry, not medicine, threw up its hands and decried this state of affairs. Leaders of major corporations refused to accept that they were powerless to help their stricken employees. They defied the rules of the game and started confronting their alcoholic employees as valuable assets that they were reluctant to lose without a fight. The concept of the Employee Assistance Program was born.

Essentially, the employer confronted the problem employee with the facts of an impaired performance record, with the presumptive diagnosis of the disease, and gave the employee the option to "shape up or ship out!"

In an earlier article, we discussed the self-preservation instincts that play a role in the life of the alcoholic, indicating that the problem carefully is kept from the workplace until the later stages of disease. This same instinct makes "job security" a vital concern in the life of the alcoholic.

When the employer confronts the alcoholic employee with this option, the employee is struck in the most vulnerable area because the most effective lever possible to "encourage" the employee to accept the employer's recommendations or ultimatum has been used. The "traditionalists" smirked and were skeptical. They warned that it would not work! Needless to say, they were the most surprised when the results were analyzed and it became undeniably certain that not only did this type of confrontation work, but that the results were much better than in the situation where we waited for the patient to be "ready."

There is a very simple and obvious reason why this is so. It is because the intervention takes place earlier in the course of these chronic progressive diseases. The condition of the patient has not been allowed to deteriorate to the point where the damage is greater, the results are much poorer, and the prognosis considerably is less favorable.

Early intervention now is the watchword, the accepted standard for all programs.

There are several important elements that are required if confrontation with our sick physician is to succeed:

1. **Specific, well-documented evidence.** We cannot intervene with rumor or hearsay. We must have positive evidence with

*Dr. Canavan is Medical Director, Impaired Physicians Program. Correspondence may be addressed to Dr. Canavan, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.

dates, times, places, and events that spell out clearly the existence of the impairment. Evidence that the confronted physician cannot refute. Here again, the issue of the "conspiracy of silence" must be dealt with. Family members, fellow physicians, and coworkers must accept their responsibility to speak out.

2. **A confrontation team composed of appropriate, meaningful members.** Considerable attention must be directed to the selection of the members of the team. Ideally, it should include a respected peer, a "recovering" physician with whom the confrontee can identify, a member of the Impaired Physicians Program, and a significant member (or members) of the physician's family.

3. **A nonjudgmental approach.** The team members must come across as supportive of the concept that the physician is impaired because of an illness that is not the physician's fault. The physician must be confronted with an attitude of "loving concern" by a group of people who care about him as a sick human being, friend, colleague, spouse, or parent.

4. **An understanding of the denial mechanism.** The team members must be skilled in breaking through the defense of denial and in leading the sick physician to an understanding and acceptance of his real diagnosis. This often requires that the confrontation be planned carefully and rehearsed thoroughly by the team members so that each team member's role and responsibilities are understood precisely.

5. **An appropriate treatment plan.** It is essential that planning includes suitable options for the appropriate treatment of the specific impairment. The treatment plan should be tailored to the nature and severity of the problem and whenever possible the personal preferences and needs of the sick physician. The leader of the intervening team should be ready and able to expedite promptly the treatment plan once it is accepted.

6. **Clout.** In the case of the rigidly recalcitrant physician, who refuses diagnosis and treatment but who obviously is seriously impaired and who poses a real risk, appropriate "leverage" is required. The only really effective lever is the physician's license to practice medicine. This gives the intervening group the same kind of "clout" that the confronting employer uses to this employee's great "advantage." This form of "clout" must be used very carefully, with appropriate safeguards. It never can be capriciously threatened or arbitrarily employed. Used properly it is most effective in convincing the unwilling physician to accept appropriate treatment.

7. **Loose ends must be tied up.** There can be many individual problems that confront the impaired physician in taking the time to get appropriate treatment. Included here are: "time off" from practice or job; coverage during the absence; funds for the treatment; and provision for the family.

The team must be ready and willing to assist in all these areas and any other areas that may need resolution before appropriate treatment can begin.

These cases usually are not emergencies. Time can be allowed to resolve these issues first rather than racing the physician off to treatment with an extra burden of nagging anxiety over unresolved, extraneous issues that could have been taken care of with a little time and effort.

It is apparent that confrontation is no small challenge; successfully carried out, its return is well worth the effort.

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WHAT IS YOUR OPINION?

Hospital Leadership

CHARLES HARRIS, M.D., Toms River**

The article, "Hospital Leadership," (January, 1983) starts out as if it would depict the equal responsibilities of the governing body and the medical staff to patient care, but then proceeds to concern itself mainly with the obligations of the physicians comprising the hospital medical staff to the hospital. There is little if any mention of the obligation of the governing board to patient care. As a matter of fact, governing boards are sort of exempted from real or actual responsibility, by virtue of the fact, as you take pains to point out, that they are ignorant of what they have chosen to govern. So they hire an administration to do this work for them, and rely heavily on these high-paid minions to keep the hospital shipshape. Meanwhile, buttressed by JCAH requirements (now a quasi-governmental agency from which the hospital requires approval before it can become eligible for Medicare/Medicaid reimbursement), the governing body loads the medical staff with responsibility for creating and adhering to its own medical standards. This is not a troika or a triumvirate, but merely an authoritative body working part time at a job about which they know little. The public would be better served if there was a degree of confrontation between medical staffs and governing bodies. Then, perhaps, there would be the system of checks and balances that is supposed to be the hallmark of this country's democracy.

The medical staff is kept so busy monitoring itself that it never bothers to look at what else is going on. To make a better hospital, doctors should enlarge the scope of their awareness to include the services the hospital is supposed to render. For example, in a $250-a-day hotel, a guest would expect that the meals be warm, the bedding comfortable, and the sheets are long enough for the bed; that enough blankets are available for warmth; that there are no flies in the room during warm weather; that temperature and humidity are uniform at all times; that the floors are clean and odors are eliminated; that patients going for x-rays are not kept in stretchers lined up in long rows in cold corridors waiting for the procedures to be performed; that nurses and aides answer bells promptly; that no patients are forced to lie in their own ordure for extended periods of time.

Years ago, as ship's doctor, I was impressed with the inspections made by the captain, who met us daily at 6 A.M. and conveyed the ship's officers from the bowels of the boat to its bridge, to see that everything was shipshape. I have never seen an administrator make thorough rounds, nor have I ever encountered one in the hospital on a weekend or at night. Their knowledge of hospital function therefore is secondhand; that of the trustees, thirdhand—maybe.

Where I work, the emergency room is in a state of continual and chaotic emergency because the infamous certificate of need legislation has created a shortage of space and personnel. Never have the trustees made a public proclamation about this execrable state of affairs; never have the trustees of New Jersey hospitals banded together to bring this issue to the attention of the communities they are supposed to serve; never have they petitioned the governor. As a matter of fact, trustees use perfidious state law as an escape hatch through which they can elude their responsibilities.

Physicians on medical staffs contribute mightily in unreimbursed time to running their end of the hospital. There are committees piled on top of committees, to an extent that appears so useless as to be ludicrous. The medical staff bylaws are replete with methods for disciplining its doctors.

Where are the rules for disciplining the administration? Where are the rules for disciplining the governing board which is responsible for deficiencies in hostelry care? Doctors who err can be kicked off the staff; doctors can be denied admission privileges because some charts of long departed patients lack signatures to unimportant notes. What happens to employees who administer hospitals in such manner that the dictated notes fail to get to the charts for four or five days? What happens to those responsible for a paucity of service and inadequate equipment? Governing boards and administrators can't keep blaming the state. Their primary responsibility should be to provide hostelry service and hospital care to the patient, law to the contrary. If necessary they must band together to change the law; they must harness the energies of their constituency to change the law for the common good.

I am indignant about the crowding in our hospitals, and the mediocrity of service that would earn immediate dismissal of the manager of even the meanest of motels. I also am getting tired of the meaningless meetings and committees established by JCAH injunction to "run" the hospitals.

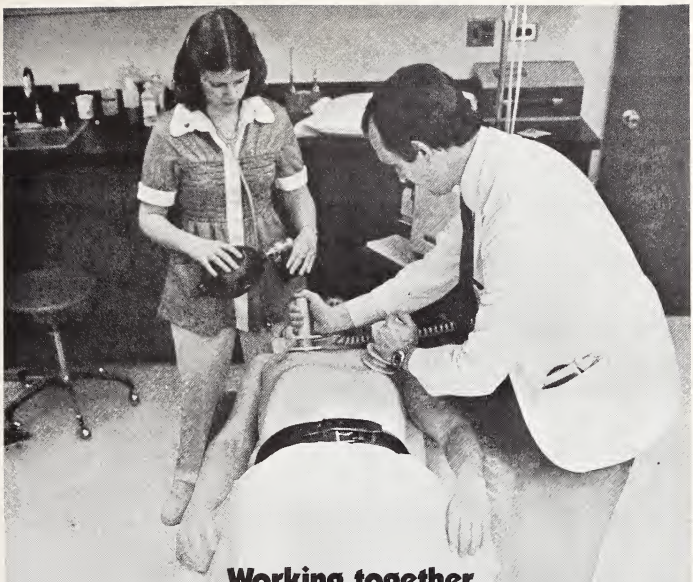
Only two committees are necessary: one manned by the trustees to assure that the medical staff provides optimum medical and surgical care; the other manned by doctors to see to it that the trustees through its administration provide the very best in hostelry care and hospital services.

Currently, whatever the reason, and every doctor knows this, the hospitals do not always meet their minimal responsibilities, unless of course, it is a trustee or staff member who is a patient.

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*We encourage our readers to write opinions on topics of interest. Send your opinion to Editor, *The Journal*, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

**Correspondence may be addressed to Dr. Harris, 20 Hospital Drive, Toms River, NJ 08753.



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Trustees' Minutes March 20, 1983

A regular meeting of the Board of Trustees was held on Sunday, March 20, 1983, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Report of the President. . .

Women Membership and Biomedical Ethics . . . Noted that Dr. Slobodien has made appointments to the Ad Hoc Committee on Women Membership and the Special Committee on Biomedical Ethics.

Report of the Executive Committee . . . Adopted the following suggested credentialing procedure for specialty society representation in the House of Delegates:

(1) Notification by the Secretary of the Medical Society of New Jersey to the specialty societies, detailing the requirements. This notification is to be mailed by June 15, and the specialty society petition must be received at the Medical Society of New Jersey by October 30.

(2) Medical Society of New Jersey staff, directed by the Secretary, will conduct a verification of the petitions. The Secretary will file his report to the Board in January.

(3) The Board will render its decision in February, then report to the House of Delegates.

Report of the Executive Director. . .

(1) MSNJ 1983 Paid Membership . . . Noted that a total of 5,748 members have paid their 1983 dues.

(2) Incentive Dues Rebate to Component Societies . . . Approved the following recommendation:

That on July 31, 1983, total 1983 paid memberships be measured against December 31, 1982, paid memberships. Component societies surpassing their December 31, 1982, membership total at that time will receive a one-time adjustment from the Medical Society of New Jersey of 50 percent of the dues collected for their additional members.

(3) Legal Matters . . .

(a) State Board of Medical Examiners and Strauch and Aluri Cases . . . Noted that the motion for MSNJ to appear amicus in both cases has been approved by the Appellate Division.

(b) State Board of Medical Examiners and Approval of Letters of Admonishment and/or Criticism . . . Noted that Mr. Maressa has requested clarification from the Attorney General on the propriety of the State Board's issuance of letters of admonishment and/or criticism.

Note: The State Board of Medical Examiners authorized its President to issue such letters in those instances when the President believes the individual should upgrade a practice; the SBME indicated that the letters are to be private and not part of the public record.

(c) Pronouncement of Death by RNs . . . Noted that the State Department of Health announced that RNs may not make pronouncements of death in long-term care facilities; this conflicts with the regulation adopted by the State Board of Medical Examiners.

(4) I.C. System, Inc. . . . Approved the endorsement of the new format of I.C. System, Inc., a collection agency.

(5) MSNJ Financial Statements . . . Reviewed and approved the February 28, 1983, financial statements.

(6) Legislation Update. . .

(a) Bill A-2057—Expansion of Physical Therapy Practice . . . Noted that proposed amendments to this bill (that would establish physical therapy as a free-standing health professon with its own regulatory board) are compatible with MSNJ's position; presently, the bill is deadlocked in the four-member Senate committee.

(b) A-2149—Optometry . . . Noted that this bill is out of committee and ready for vote in the Assembly and MSNJ hopes to stop positive action on the bill.

(c) A-784—Reporting of Disciplinary Proceedings and Malpractice Actions . . . Noted that MSNJ has requested this bill be vetoed by Governor Kean; the bill calls for the reporting to the SBME any physician who has lost clinical privileges by or through a hospital board action in New Jersey, and the reporting to the SBME of any malpractice case involving $25,000 or more.

(7) Medicaid Immunization Fees . . . Noted that no response has been received from the Commissioner of Health Services regarding the status of Medicaid reimbursement for immunization fees.

(8) Supreme Court Rule 4:21 Panels . . . Noted that operation of Rule 4:21 panels is suspended at the present time, pending final action by the Supreme Court on New Jersey.

New Jersey Hospital Association. . .

(1) Mobile Intensive Care Units . . . Noted that many hospitals are expected to reconsider the commitment to mobile intensive care units because of uncertain funding. Noted that the State is attempting to develop a demonstration project that would, in effect, reimburse hospitals for the cost of these units.

(2) Skilled Nursing Facility Reimbursement . . . Noted that the Tax Equity and Fiscal Responsibility Act (TEFRA) is expected to reduce Medicare and Medicaid payments. Noted that under TEFRA separate cost limits for hospital-based and free-standing facilities will be eliminated and that hospital-based skilled nursing facility units previously were allowed higher Medicare cost limits than those that are free-standing.

(3) Definition of Death . . . Noted that the Board of Trustees of the Hospital Association opposed **S-140**—Uniform Determination of Death Act and has offered a substitute bill.

(4) Facility Definition . . . Noted that the Hospital Association is investigating the newly opened free-standing health care facilities in New Jersey.

(5) Renal Dialysis . . . Noted that proposed changes and relevant comments from the statewide Health Coordinating Council Plan Development and Implementation Committee will be presented to the Health Care Administration Board on April 7, 1983.

(6) Special Commission on Capital Expansion . . . Noted that Governor Kean established a special commission to study and make recommendations on the use of monies for hospital facilities.

Council on Legislation . . .

(1) Ad Hoc Committee to Reassess the Society's Legislative Program . . .

(a) Reevaluation of Priorities . . . Ap-

proved the following recommendations:

(1) In order to upgrade any legislation to active support/active opposition, a two-thirds majority roll call vote *of those present and able to vote* must be received. (Italics denote editorial change by the Board.)

(2) Proposed changes to MSNJ's categories of opinions:

a. Watch List . . . for all previously designated approved/disapproved legislation.

b. Note and File . . . for all previously designated no action legislation.

c. Action Deferred . . . pending amendment that will have substantial impact on active support/active opposition legislation for all previously designated conditionally approved legislation.

(3) Each county society be contacted for its updated list of current keymen, and active use of these contacts be maintained for both federal and state legislation.

(2) Format of the Council on Legislation . . . Approved the following recommended policy:

(1) That the size and membership of the Council on Legislation remain the same and that all current legislative keymen be invited to attend the meetings of the Council *as nonvoting members.* (Italics indicate editorial insert by the Board).

(2) That quarterly meetings with specialty societies and designated members of the Council be held to update them concerning legislative activities.

(3) That members of the Council be invited by component societies to attend their local county society meetings to discuss legislative issues.

(4) That specialty societies which are members of the New Jersey Association of Medical Specialty Societies designate similar representatives to attend the Council meetings as nonvoting members.

(5) That county representation at Council meetings strongly be emphasized.

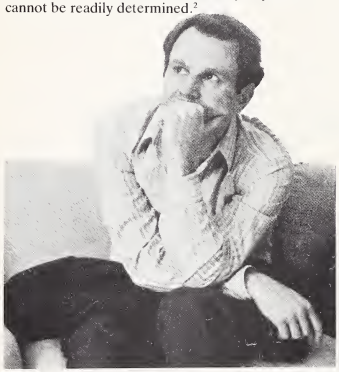
(3) Withholding of Life-Sustaining Procedures for the Terminally Ill . . . Approved the following amended recommendation:

That **S-1348, A-131, A-1099, A-1866,** and the Guidelines to Implement Procedures Concerning the Care of Comatose Noncognitive Patients (Quinlan Decision), be referred to the Executive Committees of the Medical Society of New Jersey and the New Jersey Hospital Association, for a combined effort to draft a single bill to encompass all of the points contained in the referred bills and guidelines. *The Committee on Biomedical Ethics also is to be included in the deliberation of the measure.* (Italics indicate amendment by the Board.)

(4) Current State Legislation . . . Approved the following recommendation in reference to a list of bills of medical importance:

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5,000,000 hospital patients with infections.[1] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[2]



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1. Dixon RE: *Ann Intern Med* 89(Part 2):749-753, Nov 1978. 2. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease,* edited by Goodhart RS, Shils ME; Philadelphia, Lea & Febiger, 1980, p. 1114.

Please see summary of product information on reverse page.

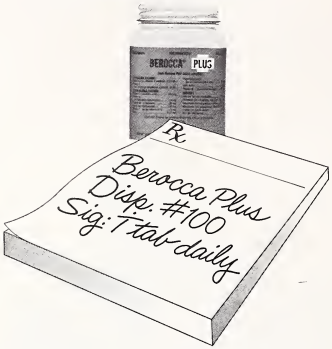
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INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals, certain conditions resulting from severe B-vitamin or ascorbic acid deficiency, or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

HOW SUPPLIED: Golden yellow, capsule-shaped tablets—bottles of 100

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That the Board of Trustees approve the positions indicated.

Council on Medical Services . . .
(1) Proposed Amendments to the Standards and Criteria for Planning and Certificate of Need of Regional End-Stage Renal Disease Service . . . Voted in favor of the Council's recommendation:

That MSNJ support the position taken by the Renal Physicians Association of New Jersey.

Committee on Finance and Budget . . . Approved the following recommendations:

(1) That the budget for the fiscal year beginning June 1, 1983, and ending May 31, 1984, in the amount of $2,650,660 with $1,974,960 to be raised through member assessments be adopted.
(2) That the 1984 assessment be set at $275.00 per regular dues-paying member. (1983 assessment is $255.00.)
(3) That the 1984 assessment be set at $25.00 per member for affiliate and associate members. (No change.)
(4) That there be an assessment for 1984 of $25.00 per member for licensed residents provided the individual is in a residency program entered upon within a reasonable time after his or her graduation from medical school. (No change.)
(5) That the 1984 assessment be set at $10.00 per student for medical students. (1983 assessment is $5.00.)
(6) That members exempt from dues because of age be requested to make voluntary contributions to MSNJ to offset the cost of mailings to these members.

Committee on Medical Aspects of School Sports. . .
Change of Committee Name. . . . Approved the following recommendation:

That the name of the Committee on Medical Aspects of School Sports be changed to the Committee on Medical Aspects of Sports.

Executive Subcommittee, Committee on Impaired Physicians. . .
(1) MSNJ Policy on Impaired Physicians Program as Refuge vs Therapy . . . Approved the following recommendation:

That the following policy statement regarding the Impaired Physicians Program as a Refuge vs Therapy be adopted: To the extent that real impairment may have made a major contribution to the legal problems of a physician that the Committee could go to the defense of the physician. However, in the event that the legal problems of the physician are not justifiably explained by or attributable to the physician's impairment, our activity should be limited to dealing with the impairment and the justice system should deal with the other aspects of the problem.

(2) Proposed Resolution Calling for the Establishment of Impaired Physicians Programs . . . Approved the following resolution for submission to the AMA House of Delegates of the 1983 Annual Meeting:

Whereas, the AMA has recognized the seriousness of the problem of impaired physicians for over ten years and has encouraged remedial programs by state medical societies; and

Whereas, every state medical society has recognized the problems of impaired physicians; and

Whereas, programs so far established by medical societies are in various stages of development with the majority not yet reaching a significant number of physicians who need a diagnosis and treatment; and

Whereas, there are a few exceptional experiences that have gone beyond initial development and are implementing programs that devote significant personnel and financial resources to this problem; and

Whereas, the commitment of such resources is absolutely essential in order to make any real progress toward alleviating this problem; now therefore be it

Resolved, that the AMA urge each state medical society to commit significant resources for impaired physicians programs that are based on the successful elements of already established programs; and be it further

Resolved, that the AMA participate in this process by retaining part-time regional consultants to facilitate and coordinate such program development by state medical societies.

Fiscal Note: It is anticipated that six to ten specially qualified consultants will need to be recruited at a cost, including staff support, estimated between $160,000 and $240,000 per year to work approximately five years on a part-time basis.

Impaired Physicians Program. . .

(1) Treatment Loan Fund . . . Noted the establishment of a treatment loan fund to assist impaired physicians into treatment and rehabilitation.

(2) Employment for Rehabilitated Physicians . . . Noted that all employment opportunities for rehabilitated physicians should be directed to Dr. Canavan.

Old Business. . .

Invitation to State Board of Medical Examiners To Designate Representative To Attend MSNJ Board Meetings . . . Expressed disappointment with the State Board's decision not to specifically designate one member to act as a liaison at MSNJ Board meetings. Approved a recommendation that MSNJ extend an invitation to the State Board to meet with the members of the Board of Trustees.

New Business. . .

(1) Resolution on JCAH Revisions to Medical Staff Standards . . . Voted to refer the following resolution to the AMA Delegation:

Resolved, that fully licensed medical doctors and doctors of osteopathy shall form the medical staff of a hospital and that health care providers with limited licenses shall form the adjunct staff of a hospital with appropriate privileges as determined by the individual hospital; and be it further

Resolved, that membership on the executive committee of a hospital shall be limited to members of the medical staff who hold a plenary license.

(2) Sandoz Medical Journalism Competition . . . Commended and congratulated the Editor and staff of *The Journal* for receiving first honorable mention in the Sandoz Medical Journalism Competition.

(3) Meeting with Commissioner of Health . . . Noted that the Commissioner expressed an interest in becoming a member of MSNJ and was considering some form of liaison between his office and the Board of Trustees.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

The three-day Semmelweis-Waters Obstetrical and Gynecological Conference held March 11-13, 1983, at Resorts International Hotel in Atlantic City is representative, if not altogether typical, of the continuing medical education that the University of Medicine and Dentistry of New Jersey provides health professionals of this and other states.

Completing its seventh annual session, Semmelweis-Waters differs from most UMDNJ continuing education programs in having a small endowment and a title with two proper names—for Ignaz Semmelweis, the 19th century Hungarian who taught physicians to prevent childbirth fever by washing their hands, and Edward G. Waters, a Jersey City physician and faculty member of UMDNJ's predecessor, Seton Hall Medical School, who gave an endowment for an annual lecture on gynecology.

More typical is the symposium that is held the following weekend in Atlantic City: "Second Annual Management of Head Trauma in the 1980s."

Nor do all UMDNJ continuing education programs convene by the boardwalk in Atlantic City, although the opportunity to combine learning and pleasure does prove attractive to physicians, other health practitioners, and their families.

Continuing education provides programs at times and in locations convenient for health professionals—in the Meadowlands, on UMDNJ's three campuses at Newark, Piscataway, and Camden, in our dozens of affiliated hospitals and on community college campuses.

Not all continuing education takes place in weekend sessions. From one-day conferences to mini-residencies, UMDNJ continually seeks innovative methods of delivering what meets the educational needs of busy professionals.

Semmelweis-Waters drew 202 physicians and 62 nurses to Atlantic City. They came from 14 states, as far distant as New Hampshire, Iowa, California, Wisconsin, and Florida and as close as Pennsylvania and New York.

Attendance is more limited at some continuing education programs. Last year more than 125 different continuing education programs attracted 5,000 participants. Supported by the UMDNJ-Office of Continuing Education staff, the total effort has grown substantially in recent years.

The faculty of UMDNJ, New Jersey's public university of health science professionals, takes an active role in updating the knowledge and skills of the attending health practitioners.

Thus, at the Semmelweis-Waters conference, UMDNJ faculty not only supplied the program chairman, Harold A. Kaminetzky, M.D., chairman of obstetrics and gynecology at UMDNJ-New Jersey Medical School, and program directors, but made several presentations among those offered by widely recognized experts from other institutions.

Some continuing education programs are conducted entirely or primarily by UMDNJ faculty members. The Semmelweis-Waters conference recruited specialists from such noted centers of medical learning as Tufts University, Columbia-Presbyterian Medical Center, University of Southern California Medical Center, Michael Reese Hospital, Chicago, and Hebrew University Medical School, Rehovot, Israel.

Listing a few of the topics at the Semmelweis-Waters conference only hints at the range of medical advances being imparted to health practitioners through continuing education: "Intrapartum Fetal Monitoring"; "Brain

Games for the Newborn: Theory and Approaches"; "Laser in Gynecologic Surgery"; "Artificial Insemination and Sex Preselection"; and "Gynecological Imaging Utilizing Ultrasound and Computed Tomography."

Like Semmelweis-Waters, some continuing education programs are limited to a single specialty. More and more, however, continuing education, like the head trauma symposium the following weekend in Atlantic City, encompasses multidisciplinary presentations by and for a wide range of health practitioners: internists, neurosurgeons, orthopedists, emergency and sports medicine specialists, nurses, paramedics, emergency medical technicians, social workers, rehabilitation specialists, and members of the legal profession.

Joining with other organizations in continuing education enables UMDNJ to stretch its resources for the benefit of the state's health professionals. Cooperating organizations in UMDNJ continuing education include the New Jersey Self-Help Clearinghouse, Hunterdon Fund, New Jersey Blood Bank Association, New Jersey Chapter of the Arthritis Foundation, Camden Area Health Education Center, and American Medical Women's Association. Pharmaceutical companies also have supported UMDNJ endeavors in continuing education.

These UMDNJ programs offer credit toward license renewal and, as in a 40-hour course being offered this spring by the UMDNJ-New Jersey Dental School for dental x-ray technicians, fulfill the prerequisite for taking the state examination. The UMDNJ Office of Continuing Education in Newark, (201) 456-4267, and coordinators at the individual schools (New Jersey Medical School, Rutgers Medical School, New Jersey Dental School, and New Jersey School of Osteopathic Medicine) are available to develop and coordinate whatever continuing education programs are needed.

MSNJ Auxiliary

Linda B. Hirsch
President

The Medical Society of New Jersey Auxiliary Executive Board meeting, held on March 14, 1983, was well attended, with discussions that covered a variety of health-related issues.

Concern continues regarding the necessity of safety seatbelts in school buses, and Board members were given direction regarding what can be done to initiate action.

Some county auxiliaries are participating in cancer detection programs, such as colorectal cancer screenings which coincide with April as Cancer Crusade Month.

There is continuing interest in combating drunken driving. It was suggested that county auxiliaries help organize and support SADD (Students Against Drunken Driving) groups in the schools.

With changes in the State Department of Education, and the demise of the Council on Gifted and Talented Education, the Board recommended support of state funding and programs for these special students.

The Board elected delegates to attend the AMA Auxiliary convention, June 19 to 22, 1983, in Chicago. The Medical Society of New Jersey Auxiliary will present a resolution to the AMA Auxiliary House of Delegates entitled, "Seminar on Stress in the Early, Middle, and Later Years of Life." This resolution will be discussed at the Health Projects Reference Committee, and our delegates will speak to support it. Briefly, the resolution requests state and county auxiliaries to conduct stress seminars, inviting experts from state and county medical societies and allied health professions to speak, with programs to include identification of symptoms of stress, techniques for prevention of stress, and treatment of stress in the early, middle, and later years of life. The Medical Society of New Jersey Auxiliary sponsored a "Seminar on Stress" during the recent Annual Meeting in Atlantic City.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Robert M. Klein, M.D., 5959 Delafield Ave., Riverdale, NY 10471. New York Medical College 1976. Subspecialty, pediatrics. Board certified, pediatrics; board eligible, immunology/allergy. Single or multispecialty group, partnership, solo, institutional. Available July 1984.

ANESTHESIOLOGY—Vithal D. Kardani, M.D., 408 Elkin Residence, 5501 North 11th St., Philadelphia, PA 19141. Shah Medical School (India) 1973. Board eligible. Group or partnership. Available July 1983.

Bharati Mistry, M.D., 74-26 45th Ave., Elmhurst, New York, NY 11373. T.N. Medical (India) 1972. Board eligible. Group, partnership, solo. Available July 1983.

CARDIOLOGY—Amarjeet Singh, M.D., 5579 Glen Hill Dr., Bethel Park, PA 15102. Patiala (India) 1971. Also, general internal medicine. Board certified (IM). Group, partnership, solo, hospital-based. Available July 1983.

FAMILY MEDICINE—William J. Rayner, M.D., 616A Country Club Parkway, Mt. Laurel, NJ 08054. New York Medical College 1975. Board certified. Group. Available July 1983.

David M. Horowitz, M.D., 2201 42nd St., NW, Apt. 103, Washington, DC 20007. NYU 1978. Also, general internal medicine. Board certified. Group or partnership. Available July 1983.

Khaja Naseeruddin, M.D., 409 North Broadway, Apt. 4S, Yonkers, NY 10701. Osmania (India) 1971. Board eligible. Group, partnership, solo.

GASTROENTEROLOGY—N.P. Narayana, M.D., 31 Minebrook Rd., Apt. 169-B, Edison, NJ 08820. Mysore (India) 1971. Also, general internal medicine. Board certified (IM). Partnership, solo, group. Available July 1983.

Joseph S. Tan, M.D., 3221 Bloomfield Lane, #505, Auburn Heights, MI 48057. University of Santo Tomas (Philippines) 1975. Also, internal medicine. Board certified (IM). Partnership, group, solo. Available July 1983.

Michael F. Fina, M.D., 633 Hertford Rd., Winston-Salem, NC 27104. New York Medical 1975. Board certified. Solo (primarily), group or partnership, second choice. Available.

Kailash Chand Singhvi, M.D., 240 Willoughby St., Apt. 10-C, Brooklyn, NY 11201. S.N. Medical College (India) 1977. Also, general internal medicine. Board eligible (IM). Group or solo. Available July 1983.

GENERAL PRACTICE—Mustafa Boyer, M.D., 168 S. Kentucky Ave., Atlantic City, NJ 08401. Istanbul (Turkey) 1943. Partnership, nursing home, hospital house physician. Available.

INTERNAL MEDICINE—Joseph S. Tan, M.D., 3221 Bloomfield Lane, #505, Auburn Heights, MI 48057. University of Santo Tomas (Philippines) 1975. Also, gastroenterology. Board certified. Partnership, group, solo. Available July 1983.

Martin Estok, M.D., 50 Wilson Ave., Newark, NJ 07105. UMDNJ 1980. Board eligible. Group, partnership, solo. Available July 1983.

David Bleeker, M.D., 200 Carman Ave., Apt. 1-C, East Meadow, NY 11554. SUNY-Downstate 1980. Board eligible. Group or partnership. Available July 1983.

Robert M. Lintz, M.D., 80 High St., Apt.

21-B, Dedham, MA. Jefferson 1978. Subspecialty, gastroenterology. Board certified. Group, partnership, solo. Available.

Stewart A. Robbins, M.D., 73-11 210th St., Apt. 2-K, Bayside, NY 11364. SUNY-Downstate 1978. Subspecialty, gastroenterology. Board certified. Group or partnership. Available July 1983.

Mel Kaplan, M.D., 48 Medinah Dr., Reading, PA 19607. New York University 1976. Board certified. Any type practice. Available.

Viswanath P. Vasudevan, M.D., 59-21 Calloway St., Apt. 5-L, Corona, NY 11368. Bombay (India) 1976. Subspecialty, pulmonary medicine. Board certified. Group or solo. Available July 1983.

Khalid I. Khan, M.D., 3317 Old Church Rd., Augusta, GA 30907. Khyber (Pakistan) 1975. Subspecialty, pulmonary medicine. Board eligible. Group or partnership. Available July 1983.

N.P. Narayana, M.D., 31 Minebrook Rd., Apt. 169-B, Edison, NJ 08820. Mysore (India) 1971. Also, gastroenterology. Board certified. Partnership, solo, group. Available July 1983.

Helen Feit, M.D., 7-J Drummond, Rocky Hill, CT 06067. SUNY-Buffalo 1980. Board eligible. Salaried position—OPD, clinic, house physician. Available July 1983.

Maureen M. Kelleher, M.D., 85 Fourth Ave., Apt. 7-C, New York, NY 10003. Harvard 1978. Board eligible. Group. Available July 1983.

Arvind Mehta, M.D., 805 North Hanover St., Anaheim, CA 92801. University of Bombay (India) 1975. Subspecialty, nephrology. Solo, partnership, group. Available January 1984.

Amarjeet Singh, M.D., 5579 Glen Hill Dr., Bethel Park, PA 15102. Patiala (India) 1971. Subspecialty, cardiology. Board certified. Group, partnership, solo, hospital-based. Available July 1983.

Kailash Chand Singhvi, M.D., 240 Willoughby St., Apt. 10-C, Brooklyn, NY 11201. S.N. Medical College (India) 1977. Subspecialty, gastroenterology. Board eligible. Group or solo. Available July 1983.

David M. Horowitz, M.D., 2201 42nd St., NW, Apt. 103, Washington, DC 20007. NYU 1978. Special interest, primary care. Board certified (FM). Group or partnership. Available July 1983.

Zakia R. Subhani, M.D., 85 Grant Ave., Colonia, NJ 07067. Liaquat (Pakistan) 1966. Board eligible. Any type practice. Available.

NEPHROLOGY—Carl S. Goldstein, M.D., 860 Gates Pavilion, 3400 Spruce St., Philadelphia, PA 19104. Washington University 1978. Also, general internal medicine. Board certified (IM). Group or partnership. Available July 1983.

OBSTETRICS/GYNECOLOGY—Francine A. Guzman, M.D., 132-17 58th Rd., Flushing, NY 11355. New York Medical 1979. Board eligible. Group or partnership. Available June 1983.

Ho Young Kim, M.D., 1945 Corlies Ave.,

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*Committee on Dietary Allowances, National Research Council: *Recommended Dietary Allowances*, ed. 9. Washington, DC. National Academy of Sciences, 1980, p. 13.

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HOW SUPPLIED: Golden yellow, capsule-shaped tablets—bottles of 100.

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Nutley, New Jersey 07110

Neptune, NJ 07753. Chonnam (Korea) 1972. Board eligible. Solo, group, partnership. Available July 1983.

Judd Goodman, M.D., 4919 Laurel Canyon Blvd., Apt. 15, North Hollywood, CA 91607. Baylor 1974. Board eligible. Solo, group, preferably in NY metropolitan area. Available.

OPHTHALMOLOGY—Michael Hostovsky, M.D., 4100 West 36th St., Minneapolis, MN 55416. Hadassah (Israel) 1972. Also, neuro-ophthalmology. Board eligible. Single or multispecialty group. Available.

Jasvinder Singh, M.D., 500 Central Ave., Apt. 702, Union City, NJ 07087. Lady Hardinge (India) 1970. Board eligible. Partnership, group, HMO. Available.

OTOLARYNGOLOGY—Richard Schiffman, M.D., 2717 East 28th St., Brooklyn, NY 11235. Tufts 1977. Board eligible. Partnership or group. Available.

Kwang H. Choi, M.D., 8704 Pellington Place, Apt. 3, Richmond, VA 23229. Seoul (Korea) 1976. Board eligible. Partnership or associates. Available July 1983.

Bruce Grossman, M.D., 215 East Chicago Ave., Apt. 1101, Chicago, IL 60611. Illinois 1978. Board eligible. Group or partnership. Available July 1983.

PATHOLOGY—Siamak Shokri-Tabibzadeh, M.D., Montefiore Hospital and Medical Center, 111 E. 210th St., Bronx, NY 10467. Tehran (Iran) 1977. Academic institution. Available.

Marvin N. Solomon, M.D., 3 Sutliff Ave., Vineland, NJ 08360. Berne (Switzerland) 1937. Special interest in anatomic and forensic. Board certified (PA); board eligible (forensic). Hospital staff, locum tenens. Available.

Pushpa Gupta, M.D., 100-C Thorndale Dr., Dayton, OH 45429. Dr. S.N. Medical College (India) 1971. Any type practice. Available.

PEDIATRICS—Shailesh J. Shah, M.D., 430 E. 67th St., Apt. 5-C, New York, NY 10021. Baroda (India) 1974. Board eligible. Special interest in pediatric hematology/oncology. Group, partnership, institutional. Available July 1983.

Renuka D. Desai, M.D., 1258 Liberty Bell Dr., Cherry Hill, NJ 08003. GS Medical College (India) 1973. Board certified. Group or partnership. Available.

Ann M. Hawryluk, M.D., 1804 Windsor Ridge Dr., Westborough, MA 01581. Harvard 1980. Board eligible. Group, partnership, HMO, solo. Available July 1983.

Edgar C. Orate, M.D., 1945 Corlies Ave., Neptune, NJ 07753. University of the East (Philippines) 1978. Board eligible. Group, partnership, solo. Available July 1983.

Alan M. Muney, M.D., 2353 Moreno Dr., Los Angeles, CA 90039. Brown 1978. Board eligible. Group or partnership. Available.

Steven Lewis Perrick, M.D., 17 Paerdegat 11 St., Brooklyn, NY 11236. SUNY-Downstate 1980. Board eligible. Partnership, solo, group. Available July 1983.

Harvey A. Hirsch, M.D., 137-03 70th Rd., Flushing, NY 11367. Guadalajara (Mexi-

co) 1978. Associate, group, partnership, HMO. Available July 1983.

PSYCHIATRY—Paul L. Maitheny, M.D., 99 Pawnee Rd., Lakewood, NJ 08701. University of Graz (Austria) 1951. Board eligible. Available.

PULMONARY DISEASES—Young J. Ko, M.D., 2927 Dorchester St., Apt. 206, Troy, MI 48084. Chonnam (Korea) 1973. Also, general internal medicine. Board certified (IM); board eligible (PM). Solo, group, partnership. Available July 1983.

M. Zaslow, M.D., 24 Westgate Rd., Chestnut Hill, MA 02167. Harvard 1977. Also, general internal medicine. Board certified (IM); board eligible (PM). Any type practice. Available.

RADIOLOGY (DIAGNOSTIC)—Kailash Tarneja, M.D., 8710-A Park Crestwood Dr., Crestwood, MO 63126. Delhi (India) 1974. Board eligible. Group, partnership, solo. Available.

Michael M. Abiri, M.D., 1077 River Rd., Edgewater, NJ 07020. Tehran (Iran) 1972. Board certified. Any type practice. Available.

A. Rama Subramaniam, M.D., 186 Ellery Ave., P.O. Box 6189, Newark, NJ 07106. Stanley Medical College (India) 1964. Special interest, nuclear medicine. Solo, group, partnership, academic, hospital-based practice. Available July 1983.

SURGERY, GENERAL—James P. Gadzik, M.D., 414 Country Lane, Narberth, PA 19072. Pennsylvania 1976. Group, partnership, general surgery (with vascular and thoracic). Available July 1983.

Matthew K.Y. Mo, M.D., 38123 Jamestown Dr., Sterling Heights, MI 48077. China Medical (Taiwan) 1974. Also, vascular surgery. Board eligible. Any type practice. Available July 1983.

SURGERY, THORACIC—John P. Hubert, Jr., M.D., 33 Viking Village, N.W., Rochester, MN 55901. Minnesota 1975. Board certified. Private practice, single specialty in small group. Available July 1983.

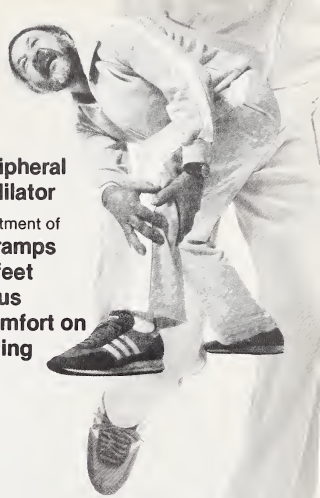
SURGERY, VASCULAR—John P. Hubert, Jr., M.D., 33 Viking Village, N.W., Rochester, MN 55901. Minnesota 1975. Board certified. Private practice, single specialty in small group. Available July 1983.

Matthew K.Y. Mo, M.D., 38123 Jamestown Dr., Sterling Heights, MI 48077. China Medical (Taiwan) 1974. Also, general surgery. Board eligible. Any type practice. Available July 1983.

UROLOGY—V.P. Nagarajan, M.D., 61 Maple Ct., Apt. 4, Snyder, NY 14226. Tirunelvel (India) 1973. Solo, group, partnership. Available July 1983.

Marc Nierman, M.D., 14 Jennings Rd., Waltham, MD 02154. Wisconsin 1978. Board eligible. Group or partnership. Available July 1983.

Gary Neal Dunetz, M.D., 310 LaGrange St., Chestnut Hill, MA 02167. SUNY-Upstate 1977. Group, partnership, multispeciality group. Available July 1984.



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REFER TO PDR

Medicine and Religion

JOSEPH H. KLER, M.D., New Brunswick

Petrus Hispanus—later Pope John XXI (1215-1277)—was the son of a Portuguese physician. Petrus Hispanus studied theology, logic, and medicine in Paris. He became Professor of Medicine at the University of Siena and in that city prepared and passed the first recorded law for the regulation of public health.

In 1247 Petrus Hispanus wrote his first medical book, *On the Role of Health*. He wrote a treatise on the care of eyes and two books, *Summulae Logicales* and *Thesaurus Pauperum* (Treasury for the Poor), in which he gave remedies for every part of the body. This became the most popular medical handbook of medicine.

Petrus Hispanus composed 17 medical works. He was crowned Pope John XXI in 1276, the only physician to date to become Pope. In the stamp, he is pictured treating a patient's eyes, and as Pope.



Petrus Hispanus
Portugal, 1977

Luke, the traditional author of the third Gospel and the Book of Acts, and the most literary among the writers of the New Testament, was the first medical man who is known to have been a Christian. He practiced medicine in Antioch at the time he met St. Paul.

The selection of stories which Luke gives us in the third Gospel reflects his own character. Luke was a religio medici, with pity for frail and suffering humanity, and with sympathy with the triumph of the divine "healing art" upon the bodies and souls of men. His name was a humane spirit with special feeling for the poor and suffering:

Luke's contribution to Christianity has been great through what he alone preserved of the historical Jesus and of the embodiment of his Gospel in his earliest followers.



St. Luke
Togo, 1978

Wooden Medicine Chest

PAUL B. SHELDON, M.D., Princeton

Almost every early physician owned a wooden medicine case similar to the one shown in the photograph. It usually sat on the doctor's office table or desk.

Pharmacies were few and far between in the 1700s and early 1800s so drugs were imported from abroad (except for home-grown herbs). Because of the limited supply of drugs, the doctor usually dispensed only enough for two or three days of treatment.

The front of the case held bottles that contained such things as turpentine (extract of lead), tartar emetic (peruvian bark), spirits of nitre (calomel flowers), syrup of ipecac (herbs), jalop (alum), and rochelle salts (bismuth). Commonly, each bottle bore its own number.

The drawers in front of the wooden chest contained a handheld balance with its set of weights, a glass or pottery mortar and pestle, and some papers for powders. In a secret compartment, out of sight and reach of patients, were bottles containing whiskey, wine, or brandy, together with smaller bottles containing opium, paregoric, laudanum.

The first such medicine cases were brought to this country by their immigrating physician-owners, but later such cases were handmade in this country as well as abroad.



Figure—Wooden medicine case.

Readers are reminded of the excellent exhibit of old medical instruments on display at the Medical History Museum, Rutgers Medical School.

LETTERS TO THE EDITOR

MSNJ Student Loan Issue

March 3, 1983

Dear Dr. Krosnick,

I realize MSNJ has no direct impact on the regional banking policies, however, I thought you might be interested in a poignant example of the quagmire through which medical students must trudge in financing their education. This is not a phenomenon isolated to this bank. The anxiety of financial uncertainty makes mincemeat of the most difficult educational tasks for the most severely affected students.

I have received two MSNJ loans for which I heartily wish to thank MSNJ. Keep up the good work; it rapidly is becoming an essential source of funds for those students lucky enough to qualify. (signed) Michael D. Achey

February 20, 1983

Dear Mr. Hoff,

I am tired of being a marionette, a figurine subjugate to the strings of bureaucratic machinations. Listen to the anger and frustration of a fourth-year medical student six months from graduation who cannot get a loan to last that short remaining time until he starts at $18,000.

I applied to your bank for a $1,050 loan under the PLUS program. I called ahead, explained I was a student, and was told cheerfully just to fill out the NJHEAA form and a personal credit application. I did. At that time, I had a $30/week income.

Low and behold, two weeks later I receive a rejection notice. Why? Because I don't have enough income. Of course I don't have enough income, I'm a student. I even had an income; certainly it was enough to cover the monthly interest payment.

Why bother to have us apply if you intend to summarily reject us out of hand. I have had to wait one and a half extra months and fill out all these forms again because you people reject students without incomes who apply for student loans. Whatever the game is, you are not playing fairly. It is a most amusing tale to tell at cocktail parties and I can't believe you would want to alienate someone who will need to borrow tens to hundreds of thousands of dollars at market rates to open a medical office.

(signed) Michael D. Achey

Multispecialty Advisory Committee of Blue Shield

January 26, 1983

Dear Dr. Krosnick:

Your readers may be interested in the activities of the Multispecialty Advisory Committee (MAC), which was formed by Blue Shield of New Jersey in 1981.

Each of 23 specialty organizations in New Jersey is represented on the MAC by a member and an alternate, chosen from nominees submitted by the organizations. Michael J. Doyle, M.D., of Monmouth County is Chairman and James P. Thompson, M.D., of Passaic County is Vice-Chairman.

Among the functions of the MAC are: to advise and recommend on general acceptability of new procedures and services; to assist in determining if procedures have progressed beyond research/experimental/investigative phase and should be reimbursable; to identify procedures which may have become outmoded; to provide input on policy recommendations to the Blue Shield Board of Trustees; and to help keep the profession informed on Blue Shield programs and policy.

We feel that the committee provides valuable two-way communication between the profession and Blue Shield, as a forum on the many matters pertinent to Blue Shield which cut across specialty lines; and we feel that it is of mutual benefit to the Plan, to the profession, and to the patients who are Blue Shield subscribers.

The committee meets quarterly, with written agenda submitted two weeks in advance. Members have been enthusiastic not only about the concept but also about the high quality of presentations by their fellow members.

Topics addressed to date include, among others: arthroscopic surgery, breast scintigraphy, collagen implant (zyderm), continuous subcutaneous insulin infusion, coronary thrombolysis, digital subtraction angiography, electrocauterization of varicose veins, endorphin analysis, fetal nonstress test, fetoscopy, Hickman/Broviac catheter, krypton laser destruction of retinal lesions, laser iridotomy, laser trabecular surgery, pan-retinal cryoablation of retinal lesions, percutaneous transluminal coronary angioplasty, plasmapheresis, radial keratotomy (twice), real-time (2-D) echocardiography, and ultrasonography of the breast.

Physicians who wish to have procedures considered by this committee may contact me or the president of their specialty society with sufficient backup documentation for reasoned consideration by a committee of the specialty society for presentation to the MAC.

(signed) Charles L. Cunniff, M.D.
Vice-President—Professional Affairs

Surgery for Breast Cancer

February 2, 1983

Dear Dr. Krosnick:

Your readers may be interested in a brief report on changing patterns of surgery for breast cancer in New Jersey.

Data were reviewed on claims paid by Blue Shield of New Jersey from 1974 through 1982 for two surgical procedures: radical mastectomy and modified radical mastectomy.

Nationwide trends toward less-radical surgery are verified by our data, as indicated below. During this time, Blue Shield enrollment essentially has been stable.

Year	Radical Mastectomy	Modified Radical	Combined Total
1974	854	424	1,278
1975	838	564	1,402
1976	756	562	1,318
1977	620	620	1,240
1978	458	661	1,119
1979	325	773	1,098
1980	246	839	1,085
1981	196	836	1,032
1982	206	858	1,064

The most likely of various reasons appears to be earlier diagnosis, related importantly to mammography and self-examination.

(signed) Charles L. Cunniff, M.D.
Vice President—Professional Affairs

Commissioner of Health

J. Richard Goldstein, M.D., of Scarsdale, New York, has been appointed State Commissioner of Health by New Jersey Governor Thomas H. Kean.

Dr. Goldstein has been involved in health care planning for more than six years. He obtained his doctor of medicine degree from the Ohio State University College of Medicine, and is licensed to practice in New Jersey, New York, Ohio, and Massachusetts.

In addition to being a licensed physician, Dr. Goldstein is an architect and former adjunct professor at the Columbia University Graduate School of Architecture and Planning. He obtained his master of architecture degree from Harvard University Graduate School of Design.

He has done facility planning work at a number of major medical institutions, including Mt. Sinai Medical Center and Bellevue Hospital Center, New York, and Newark Beth Israel and Greater Paterson General Hospital.

Dr. Goldstein practiced aerospace medicine as a flight surgeon with the United States Air Force from 1969 to 1971, also serving as Chief of Military Health at Charleston Air Force Base, Charleston, South Carolina.

He was a health facility planning consultant with E.D. Rosenfeld Associates of White Plains, New York, from 1975 to 1977. Since then, he has been a private consultant in the health care facilities and planning field.

An active researcher in medical school, Dr. Goldstein was made a member of the Landacre Society for Academic Excellence in Research at Ohio State.

The author of numerous papers, Dr. Goldstein is a member of the American



J. Richard Goldstein, M.D.

Medical Association, the American College of Emergency Physicians, the American Public Health Association, The American Institute of Architects, and the American Association of Hospital Consultants.

Dr. George Certified in Legal Medicine

James E. George, M.D., J.D., recently has been certified in Legal Medicine by the American Board of Law Medicine. Legal medicine is a specialized field dealing with the interface between medicine and the law; to be certified in legal medicine one has to be a graduate from a medical school approved by the Council on Medical Education of the AMA, be a graduate of a law school approved by the American Bar Association, be licensed to practice medicine or law, and satisfactorily have completed the examination of the American Board of Law in Medicine.

Dr. George, editor of the *Physician Legal Bulletin* and the "Professional Liability Commentary," also is recognized nationally as a knowledgeable speaker in the field of medico-legal issues.

Dr. George has served on the Board of Directors of the Medical Inter-Insurance Exchange of New Jersey (MIIENJ), as chairman of its Claims Committee. He also currently is serving as Director of the Department of Professional Liability Control, MSNJ, and as a member of MIIENJ's Risk Management Committee. Dr. George is board certified in emergency medicine, is a member of our Gloucester County component, and is an emergency room physician at Underwood-Memorial Hospital, Woodbury.

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TOPIC

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NEW JERSEY SOCIETY OF PATHOLOGISTS ANNUAL SPRING MEETING

SATURDAY, MAY 21, 1983

AT

UMDNJ-RUTGERS MEDICAL SCHOOL, PISCATAWAY, NEW JERSEY

8:00 A.M.-2:00 P.M.

ON

CLINICALLY RELEVANT QUALITY CONTROL

Program Chairman: Frederick Muschenheim, M.D.

The program is designed for all pathologists with responsibility for direction of clinical laboratories or departments of laboratories. The objectives are to demonstrate ways in which quality control activities should be designed according to clinical bedside needs, and how quality control procedures within the laboratory are pertinent to patient care. The areas of Chemistry, Microbiology, and Hematology will be considered. The speakers are leaders of the Quality Assurance Service of the College of American Pathologists.

For further information contact:

Cathy Gillmer, Executive Secretary
New Jersey Society of Pathologists
Two Princess Road, Lawrenceville, New Jersey 08648
Phone: (609) 896-1717

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June 18, 1983

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CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, The Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

June

28 Anesthesia Update
8-10 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

CARDIOLOGY

June

9 Acute Myocardial Infarction: Current Concepts and Management
8:15 a.m.-3 p.m.—Newark Beth Israel Medical Center
(Newark Beth Israel Medical Center and AMNJ)

21 Prehospital Coronary Care
12 noon—St. Mary's Hospital, Orange
(AMNJ)

MEDICINE

June

1 Thyroid Diseases
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

1 Medical Grand Rounds
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

1 CDS Prescribing Practices
11:30 a.m.-12:30 p.m.—Rahway Hospital
(AMNJ)

1 Pulmonary: Sleep Apnea Syndrome
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(AMNJ)

1 Management of the Diabetic Hypertensive Patient
1-2:30 p.m.—Christ Hospital, Jersey City
(AMNJ)

2 Medical Grand Rounds
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section of AMNJ)

2 Medical Grand Rounds
11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section of AMNJ)

3 Renal Conferences in Nephrology

17 4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section of AMNJ)

6 Rheumatoid Arthritis-Differential Diagnosis
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

7 Chronic Renal Failure
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

10 Current Clinical Concepts in Rheumatology/Immunology Lecture Series
12:15-1:15 p.m.—J.F. Kennedy Memorial Hospital, Stratford
(John F. Kennedy Hospital and AMNJ)

15 Electromechanical Properties of Tissues Magnetic Healing of Bones
10:30 a.m.—South Bergen Hospital, Hasbrouck Heights
(AMNJ)

15 Detection and Management of Skin Cancer

22 Adolescent Sexuality
1:30-2:30 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

15 Rutgers Dermatological Conference
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ-Rutgers Medical School and AMNJ)

16 Changing Indications for Open Heart Surgery-Medical and Surgical Perspectives
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

16 Monoclonal Antibodies: Their Potential in the Diagnosis, Prognosis, and Therapy of Cancer
9-11:30 a.m.—Newark Beth Israel Medical Center
(Newark Beth Israel Medical Center and AMNJ)

21 Nephrology Lectures
7:30-8:30 p.m.—Ramada Inn, Clark
(Nephrology Society and AMNJ)

21 Theories on the Etiology of Essential Hypertension
4-5 p.m.—Academic Health Science Ctr., Medical Education Bldg., New Brunswick
(UMDNJ-Rutgers Medical School and AMNJ)

21 Fluid and Electrolyte Imbalance
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

24 Alternatives to Ileostomy and Colostomy
12 noon-1 p.m.—Perth Amboy General Hospital
(AMNJ)

NEUROLOGY/PSYCHIATRY

June

1 A Case of Mitral Valve Prolapse Presenting as Panic Anxiety
3-4:30 p.m.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)

1 Child Psychiatry Case Conference

8 10 a.m.-12 noon—Trenton Psychiatric Hospital

15 *(Trenton Psychiatric Hospital and AMNJ)*

22

29

2 CCMA-Clinical Lectureship

16 Imagery and Fantasy as Therapy Techniques

30 Assaultive Patients-Traumatized Staff
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

3 Dual Diagnosis
1:15-2:30 p.m.—Marlboro Psychiatric Hospital
(McNeil Pharmaceutical and AMNJ)

6 Preschooler's Reaction to Violent Death
8:15-10:30 p.m.—1046 South Orange Avenue, Short Hills
(Essex Psychiatric Seminar and AMNJ)

6 Psychiatric Case Conference

13 7:30-11:30 a.m.—Trenton Psychiatric

20 Hospital

27 *(Trenton Psychiatric Hospital and AMNJ)*

8 Legal Issues in the Care of Psychiatric Patients

22 Rapid Tranquilization of the Acutely Psychotic Patient

29 Assaultive Patients: Traumatized Staff
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

9 CAT Scanning in a Psychiatric Population
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

NYU MEDICAL CENTER
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presents:

June
3-8 Interventional Radiology and Digital Imaging
6-8 Obstetrical Ultrasound
8-12 Computed Tomography
10-11 Otolaryngology Update
13-16 Emergency Medicine 1983
20-23 Pediatric and Adolescent Medicine

Information: NYU Post-Graduate Medical School, 550 First Avenue, New York, NY 10016 (212) 340-5295

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9 Adolescent Alcoholism
2-3 p.m.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

20 Principles of Child Psychotherapy
8:30-10:30 p.m.—Office of Lawrence Deutsch, M.D., 301 Broad Ave., Englewood
(New Jersey Psychoanalytic Society and AMNJ)

22 Compulsive Gambling: A Recognized Disease
9 a.m.-4:30 p.m.—Golden Nugget Casino, Atlantic City
(Carrier Foundation and AMNJ)

July

4 Psychiatric Case Conferences
11 7:30-11:30 a.m.—Trenton Psychiatric
18 Hospital
25 *(Trenton Psychiatric Hospital and AMNJ)*

6 Child Psychiatry Case Conferences
13 10 a.m.-12 noon—Trenton Psychiatric
20 Hospital
27 *(Trenton Psychiatric Hospital and AMNJ)*

7 Sexual Dysfunction: Update 1983
14 Alzheimer's Disease and Family Dynamics
21 Strategies To Break Through Psychotic Isolation
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

OBSTETRICS/GYNECOLOGY

June

2 Annual Meeting
9 a.m.-12:30 p.m.—Monmouth Park Racetrack, Long Branch
(NJ Obstetrical and Gynecological Society and AMNJ)

15 Estrogen Replacement Therapy: Osteoporosis
1-2 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

PEDIATRICS

June

2 Child with Dysmorphic Features
9 a.m.—Freehold Area Hospital
(AMNJ)

10 Changing Concepts in the Treatment of Seizures: The Value of the New Anticonvulsive Medications
8:15-9:45 a.m.—Overlook Hospital, Summit
(Overlook Hospital, Columbia University College of Physicians and Surgeons, and AMNJ)

20 The Floppy Infant
12 noon-1 p.m.—The Mountainside Hospital, Montclair
(The Mountainside Hospital and AMNJ)

RADIOLOGY

June

1 Cost Efficient Use of Newer X-ray Techniques
1:30-2:30 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

2 Columbia Affiliate Radiology Lecture Series
5:30-6:30 p.m.—Morristown Memorial Hospital
(Overlook Hospital, Morristown Memorial Hospital, and AMNJ)

11 Real-Time, Cross-Sectional Sector Scanning
9 a.m.-5 p.m.—Nassau Inn, Princeton
(The National Foundation for Noninvasive Diagnostics and AMNJ)

27 Basic and Advanced Echocardiography, and Real-Time, Cross-Sectional Sector Scanning
Sands Hotel & Casino, Atlantic City
(The National Foundation for Noninvasive Diagnostics and AMNJ)

July

1 Basic and Advanced Echocardiography, and Real-Time, Cross-Sectional Sector Scanning
Sands Hotel & Casino, Atlantic City
(The National Foundation for Noninvasive Diagnostics and AMNJ)

SURGERY

June

1 Surgical Department Conference
8 8:30-10 a.m.—Rutgers Medical School,
15 New Brunswick
22 *(UMDNJ)*
29

11 Colorectal Cancer
8 a.m.-3 p.m.—NJ Medical School, Newark
(UMDNJ and AMNJ)

July

6 Surgical Departmental Conferences
13 8:30-10 a.m.—Rutgers Medical School,
20 New Brunswick
27 *(UMDNJ)*

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastics, and Vascular Surgery)

June

2 Vascular Conference Rounds
9 4-5 p.m.—Rutgers Medical School,
16 New Brunswick
23 *(UMDNJ)*
30

July

7 Vascular Conference Rounds
14 4-5 p.m. Rutgers Medical School,
21 New Brunswick
28 *(UMDNJ)*

The Journal of the Medical Society of New Jersey
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September, 1983

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OBITUARIES

Dr. Sanel Beer

Word has been received of the death of Sanel Beer, M.D., on July 18, 1981. Dr. Beer was born in 1886 and received a medical degree from the University of Vienna in 1913. Dr. Beer was a retired member of our Essex County component and a member of the American Medical Association.

Dr. Alexander R. Dimond

At the untimely age of 39, Alexander R. Dimond, M.D., a member of our Bergen County component, died on December 31, 1982. Dr. Dimond earned a medical degree at Downstate Medical Center, New York, in 1943. He was a urologist at Valley Hospital, Ridgewood. Dr. Dimond was a Diplomate of the American Board of Urology and a member of the American Medical Association.

Dr. Haynes H. Fellows

Word has been received of the death of Haynes Harold Fellows, M.D., on October 5, 1982. Born in 1891, Dr. Fellows received a medical degree from Cornell University Medical College, New York, in 1918. During his lengthy career, he was affiliated with New York Hospital. Dr. Fellows was a retired member of our Essex County component and a member of the American Medical Association. In 1968, Dr. Fellows was a recipient of MSNJ's Golden Merit Award, honoring his 50 years as a medical practitioner.

Dr. Frederick Lerman

Frederick Lerman, M.D., died on February 18, 1983. Born in 1920, Dr. Lerman earned a medical degree from New York University School of Medicine in 1944. During his lengthy career, Dr. Lerman was affiliated with General Hospital, Alexian Brothers Hospital, and St. Elizabeth Hospital, all in Elizabeth. Dr. Lerman was a Diplomate of the American Board of Urology, a Fellow of the American College of Surgeons, and a member of our Union County component and of the American Medical Association.

Dr. John J. McCarthy

At the age of 76, John Joseph McCarthy, M.D., died on February 3, 1983. Dr. McCarthy earned a medical degree at Georgetown University School of Medicine, Washington, D.C., in 1932. Dr. McCarthy was an obstetrician with a practice in North Bergen; he retired two years ago. During his career, Dr. McCarthy was affiliated with Holy Name Hospital, Teaneck, and Hague Hospital, Jersey City. Dr. McCarthy was a member of our Hudson County component and of the American Medical Association, a Diplomate of the American Board of Obstetrics, and a Fellow of the American College of Obstetricians and Gynecologists.

Dr. Ronald C. Nayfield

At the age of 71, Ronald Cornelius Nayfield, M.D., died on February 20, 1983. Dr. Nayfield received his medical degree from Jefferson Medical College, Philadelphia, in 1936. Dr. Nayfield was the former chief of obstetrics at Mercer Medical Center, Trenton. Dr. Nayfield was a Diplomate of the American Board of Obstetrics, a Fellow of the American College of Obstetricians and Gynecologists, and a member of our Mercer County component and of the American Medical Association.

Dr. Jack J. Peril

A member of our Camden County component, Jack Jerome Peril, M.D., died on February 21, 1983. Born in 1930, Dr. Peril was graduated from Jefferson Medical College, Philadelphia, in 1956. Dr. Peril was affiliated with West Jersey Health System, Eastern Division, Voorhees, and Northern Division, Camden. Dr. Peril was a member of the American Medical Association, and a Fellow of the American College of Angiology and of the International College of Angiology.

Dr. Peter W. Ross

Peter William Ross, M.D., died on January 30, 1983. Born in 1907, Dr. Ross earned a medical degree at George Washington University School of Medicine in 1933. Dr. Ross practiced as a urologist for 49 years in Clifton. He was a member of our Passaic County component and of the American Medical Association, a Diplomate of the American Board of Urology, and a Fellow of the American College of Surgeons. During his lengthy career, Dr. Ross was affiliated with St. Mary's Hospital, Passaic.

Dr. Eli Starr

Word just has been received of the death of Eli Starr, M.D., on November 11, 1982. Dr. Starr was born in 1910 and earned a medical degree at the University of Vienna in 1937. Dr. Starr was a radiologist affiliated with North Hudson Hospital, Weehawken. Dr. Starr was a Diplomate of the American Board of Radiology and a member of the American Medical Association and of our Hudson County component.

Dr. George S. Stevenson

At the grand age of 90, George Salvadore Stevenson, M.D., died on February 9, 1983. Dr. Stevenson earned a medical degree at Johns Hopkins University School of Medicine, Maryland, in 1919. He was a retired member of our Monmouth County component, a member of the American Medical Association, and a Diplomate of the American Board of Psychiatry. During his lengthy career, Dr. Stevenson was affiliated with Marlboro Psychiatric Hospital. Dr. Stevenson was a recipient of MSNJ's Golden Merit Award in 1969.

Dr. Ralph S. Wright

Ralph Stanger Wright, M.D., a past president of our Camden County component, died on February 12, 1983. Born in 1898, Dr. Wright was graduated from Hahnemann Medical College, Philadelphia, in 1924. He was a retired member of our Camden County component, a member of the American Medical Association, a Diplomate of the American Board of Urology, and a Fellow of the American College of Surgery. Dr. Wright received MSNJ's Golden Merit Award in 1974, in honor of 50 years as a physician.

Circulation of the Blood: Men and Ideas

A.P. Fishman and D.W. Edwards (eds), Bethesda, MD, The Williams and Wilkins Company, 1982. Pp. 859. ($56)

The average physician who glances casually at the title of this mammoth book will say quite naturally, "Oh yes, here's another biography on the epochal life and work of William Harvey." Indeed, he will be mistaken, for *Circulation of the Blood: Men and Ideas* with contributions by 16 eminent physiologists provides us with much more than a slavish adulation of the "discoverer" of the circulation. Instead, incorporated in these pages is much historical material by which the authors prove conclusively that Harvey's predecessors from antiquity to his own times understood the basic elements of the circulation and already were hot on the trail of the truth. In fact, Andre Cournand, the Nobel prize winner, who sets the tone for the entire volume with an illuminating overview of the subject, quotes from a contemporary of Hippocrates, who lived over 2,000 years ago: "The heart and the vessels are perpetually moving, and we may compare the movement of the blood with courses of rivers returning to their sources after a passage through various channels."

Nowhere in my readings have I found a more orderly nor a more lucid account of the various theories concerning the lesser or pulmonary circulation, including the retarding effect of Galen's "invisible pores," and the progressive contributions of the Arab ibn-Nafis (13 c.), Vesalius, and Servetus who finally clearly outlined the lesser circulation in 1553. Strangely enough the work of Servetus, buried in a discredited theological tract, escaped the attention of Harvey and other scientists, and was only rediscovered by Richard Lower at the very end of the 17th century. The rise of chemistry by mid-18th century and the discovery of oxygen by Lavoisier and Priestley added more information concerning the exchange of gases in the human system.

Although the various chapters undoubtedly were read and discussed by the authors, there is some overlapping, especially in the historical references. The chapter on coronary circulation is a masterpiece, incorporating an account of the discoveries (unhappily concealed for two centuries) of the work of the great Leonardo da Vinci and giving Harvey full credit for putting the missing pieces together; continuing finally with the English clinician, Heberden, who defined with uncanny accuracy the symptoms and progress of angina pectoris. The account ends with the advent of the electrocardiograph.

The second portion of the book is devoted to the blood vessels, beginning with the discovery of the capillaries by Malphigi and the microscopist Leeuwenhoek, advanced by Johannes Muller and continued by a host of researchers down to Starling. Remaining chapters concern vasomotor control and the regulation of blood pressure, including the account of the original work of the Reverend Stephen Hales.

This leads us to the third part directed to the special circulations, namely the renal, splanchnic, and cerebral, and this amazing volume ends with illuminating chapters on the prenatal and perinatal circulations.

I have seldom reviewed a book which has made me feel so indebted to it, and I predict that no physician who reads it through will come away with a different opinion. Illustrated with almost 250 line drawings I feel certain that it will soon become a collector's item and urge every physician and certainly every cardiologist who takes pride in his profession to acquire a copy.

Morris H. Saffron, M.D.

How To Write and Publish Papers in the Medical Sciences

Edward J. Huth, M.D. Philadelphia, PA, ISI Press, 1982. Pp. 203.

The author, in his introduction, asserts a need for a concise and practical book dealing specifically with medical writing. The book is divided into 20 chapters. There are chapters dealing with literature search techniques, preparing to write, the basic structure of papers, drafting, and revision. There are individual chapters devoted to types of scientific papers, e.g. the case report, research paper, review, editorial, book review, and letter to the editor. The reader can refer to a specific chapter to learn the basic structure he or she should follow for each type of article. There is a section on preparation of tables and illustrations. A very useful chapter discusses responses to an edited paper that has been rejected or returned for revision. The author gives very practical advice on whether to resubmit a paper or to seek another journal. There is a short useful chapter on editing including the more common proofreader's marks and their proper use.

There are five appendices. The first appendix is a short outline summarizing the objectives as previously delineated in the text. Three appendices deal with reference sources dealing with various aspects of writing papers. The last appendix is the bibliography of works cited.

This book is easy to read. It is packed full of information one usually has to go to multiple sources to obtain. There are many practical hints and suggestions on writing that often require years to accumulate on your own. The chapters cover a subject but are not cumbersome to read. I recommended this book to several colleagues shortly after reading it. It can be used as a handbook for intermittent referral or as a text for beginning writers.

Robert M. MacMillan, M.D.

Medical Law for the Attending Physician: A Case-Oriented Analysis

Salvatore Francis Fascina, M.D., J.D. Carbondale, IL, Southern Illinois University Press, 1982. Pp. 485. ($40)

This comprehensive text addresses a host of clinicolegal problems that concern practicing physicians. Succinct and neatly organized, this book ideally is suited for self-study as well as for use in a formal medical school curriculum.

The book is divided into two parts. Part 1, a compilation of case studies from actual malpractice cases, is fol-

owed by a collection of clinicolegal eaching cases. The case studies repre- ent a distillation of pertinent linicolegal facts from over 250 decided nedical malpractice cases. The author weaves these case studies into nine chap- ers covering a wide range of medico- egal topics. The chapters demonstrate now the courts tend to view and measure professional conduct in light of particu- ar facts and circumstances. Topics in- clude legal aspects of the physician-pa- tient relationship, the physician's liabil- ity for mistakes in diagnosis, consent problems, patient records, and liability of the attending physician in a consult- ing situation.

Part II is an ambitious and laudable attempt to illustrate the often-stated principle that good medicine is good law. Over 60 clinicolegal teaching cases are organized by clinical specialty and emphasize legally acceptable standards of care. The cases illustrate principles highlighted in Part I of the book and were gleaned from cases that ripened into litigation.

A most interesting case cited by Dr. Fascina is that of Johnson v. Women's Hospital, 527 S.W. 2d 133 (1975). Mrs. Johnson delivered a premature infant that expired shortly after birth. Her at- tending physician told a hospital nurse to advise Mrs. Johnson that the hospital could handle the disposal of the body or arrange for burial. The nurse did not relate this information but simply told Mrs. Johnson that the hospital would "probably take care of everything." The hospital kept the infant's body in its pathology department.

While at her physician's office for her six-week postpartum checkup, Mrs. Johnson was given her medical chart to pass on to the physician. She noted a report on the chart stating that the body could not be disposed of as a surgical specimen. When she confronted her phy- sician, he instructed one of his nurses to accompany Mrs. Johnson to the hospital to look into the matter. When Mrs. Johnson inquired as to the manner of disposition of her infant, a clerical em- ployee in the pathology department presented her with her infant's shrivelled body in a large glass jar filled with formaldehyde. Mrs. Johnson was shocked. She sued the hospital.

The court held that the hospital's con- duct was "outrageous." It went beyond the bounds of decency in that it reckless- ly disregarded the sensitivities of Mrs. Johnson, even though it should have been obvious that such conduct could cause severe emotional distress.

The text is supplemented by a table of cited cases and a glossary of legal terms. The absence of legal jargon and rhetoric regarding the malpractice crisis is strik- ing and refreshing.

The serious, scholarly, and practical volume deserves praise and a place on the reading list of every practicing physi- cian who is concerned with conforming professional conduct to the require- ments of the law. Its author, Salvatore Francis Fascina, M.D., J.D., is Deputy Chairman, Department of Legal Medi- cine, Armed Forces Institute of Pathology, and Professional Lecturer at the George Washington University Na- tional Law Center.

James E. George, M.D., J.D.

The Medical Teacher

Kenneth R. Cox and Christine E. Ewan (eds). New York, NY, Churchill Liv- ingstone, 1982. Pp. 248. ($25)

The Medical Teacher is in fact a man- ual for educators in both medical schools and universities. It is a well- organized compendium of operational techniques and specific directions de- signed to make teaching more effective. This book is clearly organized so that users easily can locate the topic under consideration. It also provides back- ground and explanation concerning the use of pedagogic principles in addition to specific teaching techniques.

Five topics are contained within sepa- rate sections—the learner, the teacher, the methods, the resources, and the assessment. The book begins with an exposition of applicable principles of learning useful to students. The major portion centers around methods of educating, i.e. planning of lectures, help- ing students learn in tutorials, and the teaching of interviewing skills. The re- sources section is extensive. It covers a full array of techniques available to help the instructor, e.g. the preparation of original graphics, using slides, clinical simulation, and teaching with television. The book concludes with an examina- tion of ways to evaluate performance. Although examination construction and application are thoroughly discussed, this section is more difficult to use than the others.

This is a highly recommended book for the serious educator. It is a valuable reference to be consulted at virtually every step in the education process. One criticism concerns the fact that by its title this volume is directed toward medi- cal educators exclusively. In fact, it has considerably wider application and with only slight modification could have a much larger audience; the entire field of higher education would benefit.

Michael H. Miller, Ph.D.

Vascular Emergencies

Henry Haimovici, M.D. New York, NY, Appleton-Century-Crofts, 1982. Pp. 634.

Vascular Emergencies is a surprisingly good book. One has come to expect a multiauthored text to be incomplete and patchy in quality, yet this text, written by a dean of vascular surgery in the United States as well as one of its his- torians, is balanced throughout, and covers an unusually wide variety of im- portant subjects. The balance is typified by a thorough review of noninvasive and invasive methods for evaluating vascular emergencies, as well as of special types of angiography.

Haimovici has not ignored the whole patient, in that he has included full descriptions of hemorrhagic and throm- botic disorders that may lead to vascular emergencies, and also the manifestations and management of surgical shock, ad- mirably addressed by Cohen and Del Guercio. This section of the book is amplified further by an indepth analysis of multiorgan failure. Pre- and post- operative monitoring also is included.

The book covers the gamut of vascular emergencies, both arterial and venous. Trauma to arteries, both iatrogenic and noniatrogenic, is well covered, as are such esoteric topics as the vascular damage produced by drug self-administration.

Haimovici has written a great deal of the book himself, but where necessary, he has called upon well-recognized ex- perts to augment the text. For example, Crawford and his colleagues discuss the management of thoracic aneurysms so well that if the reader were brave enough he might be willing to tackle some of these lesions himself, aided solely by the profusely illustrated presentations. The only venous disease not considered is portal hypertension which justifiably belongs in a text of its own.

I find this book to be unusually in- structive, thorough, easy to read, and not ponderously lengthy or detailed. It is referenced copiously, and without a doubt will be a most valuable addition to the library of anyone interested in vascular surgery.

Victor Parsonnet, M.D.

Personnel

See Pages 395 and 396

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Real Estate

see Page 395

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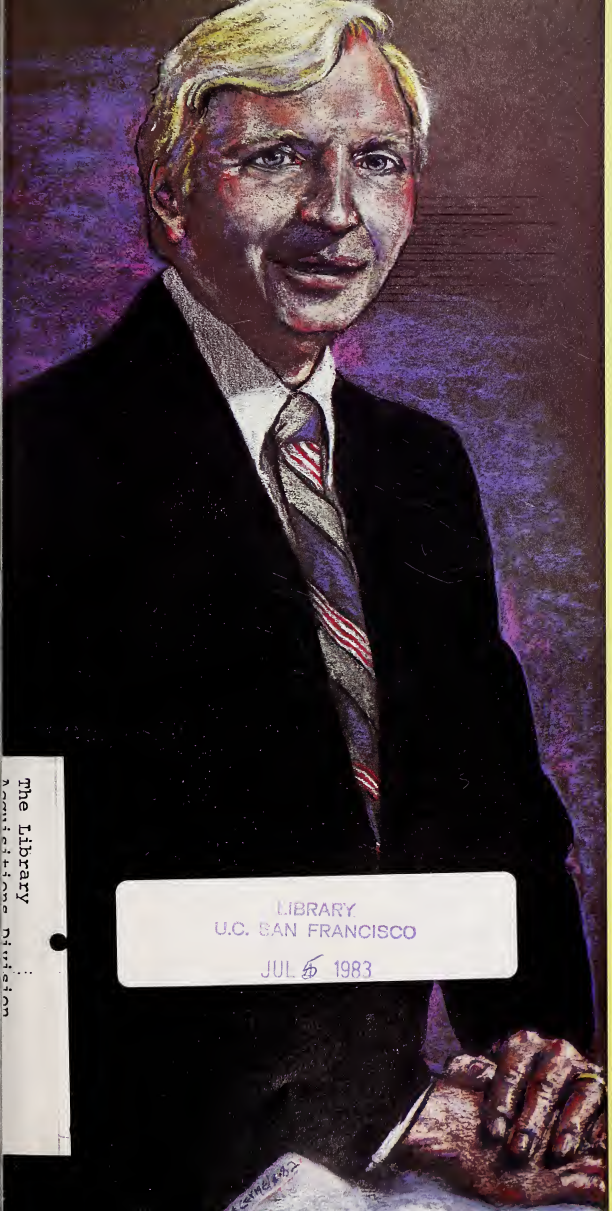
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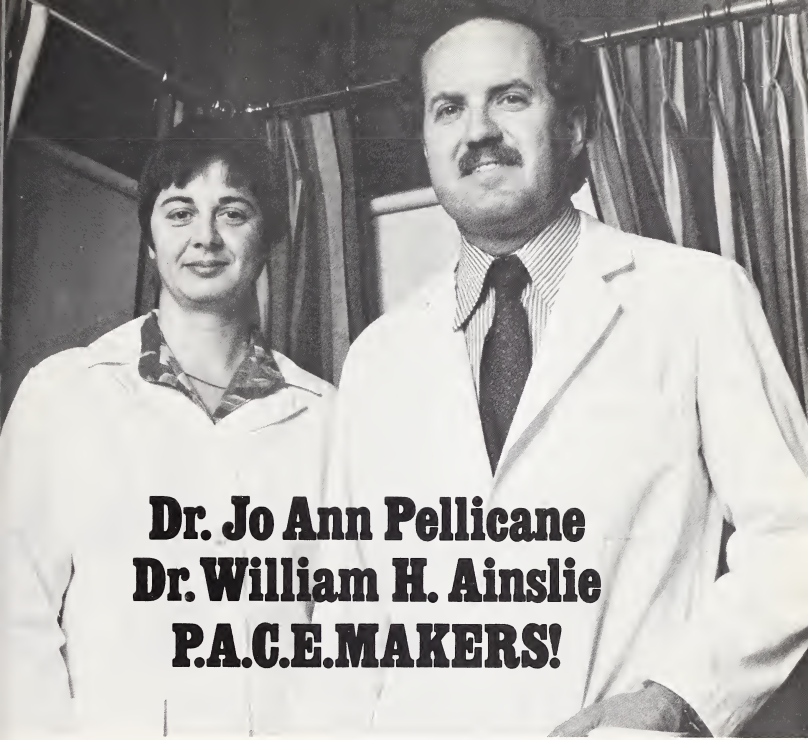
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On The Cover: We extend our hearty congratulations to Alexander D. Kovacs, M.D., and wish him a successful, happy, and healthy term as the 191st President of the Medical Society of New Jersey. An editorial on our new president appears on page 407 and Dr. Kovacs's inaugural address begins on page 413. Cover illustration is by Susan Cermele.

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More Than A Consent Form and Doing Your Own Surgery

Patients have the right to choose their form of treatment or surgical procedure. Physicians have the responsibility to provide easily understood information that will aid the patient in arriving at an intelligent decision regarding an intended treatment or procedure.

The early concept of informed consent dealt solely with whether a patient consented to treatment. The consumers' rights movement, the malpractice crises of the 1970s, and a growing body of case law have resulted in a refinement of the concept of informed consent.

Courts have determined that it is not enough for physicians to get a patient's consent, but the physician has a responsibility to discuss five items of information with the patient:

1. What is to be done;
2. Why it should be done;
3. By whom it will be done;
4. What risks are associated; and
5. What alternative methods are available.

Despite the concerns of how much should be told to patients, it generally is agreed that "physicians should accept education of the patients through the process of informed consent as a worthwhile therapeutic goal."[1]

A well-known study, conducted in the mid-1970s, regarding patient retention of the physician's discussion of the proposed treatment or procedure, often is cited as a rationale for maintaining meticulous records of such a discussion.

George Robinson, M.D., and Avraham Merav, M.D., tape recorded informed consent conversations with their patients. "[Those] recordings were made with the knowledge and permission of the patients. In a carefully structured but informal session one or two days prior to operation, the elements of informed consent were covered systematically in considerable detail."[2]

Four to six months after the procedure 20 patients were interviewed to determine their recall of the discussion. "Despite meticulous attention to detail by the physician in a carefully conducted informed consent procedure, all 20 of the patients . . . failed to recall accurately what had transpired at their interview."[2]

This study should alert physicians that it is "essential to document in some way the details of informed consent so that it becomes a permanent part of the clinical record, since memory of the event is unreliable."[2]

"It is important to distinguish between informed consent and the consent form. A patient may feel compelled to sign a consent form even when the doctor has not explained the treatment. In such cases, of course, there is no informed consent. 'By failing to distinguish between informed consent and its documentation, the legal profession has precipitated the most egregious misconcepton by physicians concerning informed consent—namely, that if a consent form is signed, informed consent is given.' (Vaccarino, 1978)."[3]

Three groups may benefit from the use of consent forms: patients, doctors, and hospitals in which the treatment is given. Patients benefit because consent forms help them to exercise their right to give informed consent. Consent forms remind doctors that patients have a right to information about treatment and about the alternative choices available to them. Doctors benefit because consent forms may help to resolve misunderstandings in malpractice suits. When a medical procedure has an unfavorable outcome, patients or their relatives may not remember that the patient was informed of this possibility. The consent form can serve as a record to protect the doctor. Hospitals benefit because consent forms can serve to separate hospitals from malpractice disputes between doctors and patients. Indeed hospitals, on the advice of the lawyers who represent them, are very active in promoting the use of consent forms."[4]

NEW YORK PROPOSED MALPRACTICE REFORM

Attempting to come to grips with the medical malpractice crisis in New York state, a coalition of interested parties will present seven proposals for enactment by the legislature.

The coalition comprises the state medical and hospital societies, several state insurance and business groups (including the Blues), and seven national medical and insurance organizations.

The high cost of malpractice insurance, currently $37,000 a year for a Long Island obstetrician-gynecologist, has caused many physicians to consider moving or taking early retirement, according to Richard D. Eberle, M.D., president of the state society. Dr. Eberle stated: "Many young doctors appear to be opting out of the state at a growing rate."

The seven proposals for legislative enactment are:

1. A $100,000 limit on compensation for pain, suffering, and other "noneconomic" losses.

2. Ending lump-sum payments for future damages, such as loss of earnings.

3. Establish a graduated contingency fee schedule for plaintiffs' attorneys, ranging from 50 percent of the first $3,000 recovered to 10 percent of any amount over $100,000.

---

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Director of Special Projects.

Presently an attorney can collect up to one-third of any payment.

4. Establish regional boards of physicians and laypersons to hear complaints about treatment and billing. Presently only the state board assumes this role.

5. Require an expert witness to be practicing actively and to have either board certification or hospital privileges.

6. Require plaintiffs' attorneys to file a "certificate of merit" which certifies that the attorneys reviewed the case, consulted with a qualified physician, and determined what action to follow.

7. Require plaintiffs to post a bond when they pursue a claim, despite an unanimous ruling of the state's three-person screening panel favoring the defendant. When the three-person panel unanimously finds for the plaintiff, and the defendant refuses to settle, the defendant must post a bond to cover costs and fees should the case be lost at trial.

"The high cost of malpractice insurance has caused many physicians to consider moving or taking early retirement."

The coalition expects the plaintiffs' attorneys to oppose the changes, but the group will approach the state bar for discussion of the proposals.

Douglas Barnert, an insurance executive and chairman of the coalition, stated, "We don't expect the bar to jump for joy, but I think we'll get a reasonable response."

Mr. Barnert's optimism maybe short lived, when one considers the response of Richard Shandell, president of the State Trial Lawyers Association. According to Mr. Shandell (*Medical World News*, Feburary 14, 1983): "These proposals aren't reforms. They're an attempt by doctors to achieve immunity from the law."

SURGEONS MUST DO OWN SURGERY

Patients have a legal right to be operated on by the doctor who agrees to perform the surgery, reported the *Trentonian* newspaper regarding the New Jersey Supreme Court ruling of March 2, 1983. In a 6-0 decision, the state's highest court said doctors who have colleagues stand in for them after telling the patient they themselves would do the surgery could be sued for malpractice if damages occurred. In turn, the doctor who performs the surgery can be sued for battery, the court added.

"It is malpractice whether the right surgeon operates on the wrong part or the wrong surgeon operates on the right part of the patient. In each instance, the surgeon has breached his duty to care for the patient," Associate Justice Stewart Pollack wrote for the court. "Absent an emergency, patients have the right to determine not only whether surgery is to be performed on them, but who shall perform it," he added.

The decision stemmed from a suit filed by a plaintiff against three doctors. In May, 1977, the plaintiff signed a consent form naming the defendant-physician as the doctor authorized to remove his kidney stones.

But the defendant did not attend the surgery. Instead, it was performed by two associates. (The doctors customarily shared patients in their practice.) On learning what was done, the plaintiff and his wife sued all three.

A jury decided in favor of the doctors and the Appellate Division of the Superior Court upheld the ruling. But the Supreme Court reversed the ruling.

OPINION OF THE JUDICIAL COUNCIL OF THE AMA: SUBSTITUTION OF SURGEON

To have another physician operate on one's patient without the patient's knowledge and consent is a deceit. The patient is entitled to choose his own physician and he should be permitted to acquiesce in or refuse to accept the substitution. The surgeon's obligation to the patient requires him to perform the surgical operation: within the scope of authority granted by the consent to the operation; in accordance with the terms of the contractual relationship; with complete disclosure of all facts relevant to the need and the performance of the operation; and to utilize his best skill in performing the operation.

It should be noted, it is the operating surgeon to whom the patient grants consent to perform the operation. The patient is entitled to the services of the particular surgeon with whom he contracts. The surgeon, in accepting the patient, is obligated to utilize his personal talents in the performance of the operation to the extent required by the agreement creating the physician-patient relationship. He cannot properly delegate to another the duties which he is required to perform personally.

Under the normal and customary arrangement with private patients, and with reference to the usual form of consent to operation, the surgeon is obligated to perform the operation, and may use the services of assisting residents or other assisting surgeons to the extent that the operation reasonably requires the employment of such assistance. If a resident or other physician is to perform the operation under the guidance of the surgeon, it is necessary to make a full disclosure of this fact to the patient, and this should be evidenced by an appropriate statement contained in the consent.

If the surgeon employed merely assists the resident or other physician in performing the operation, it is the resident or other physician who becomes the operating surgeon. If the patient is not informed as to the identity of the operating surgeon, the situation is "ghost surgery."

An operating surgeon is construed to be a performing surgeon. As such, his duties and responsibilities go beyond mere direction, supervision, guidance, or minor participation.

The physician is not employed merely to supervise the operation. He is employed to perform the operation. He can properly utilize the services of an assistant to assist in the performance of the operation, but he is not performing the operation where his active participation consists merely of guidance or standby responsibilities in the case of an emergency.

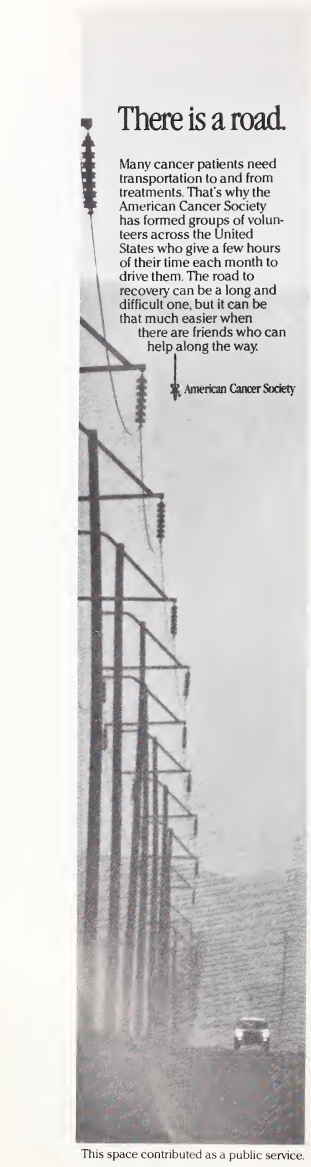
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BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina, also called exertional angina) in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catechol amines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. When patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request

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"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

*Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page*

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Alexander D. Kovacs, M.D.—191st President

Although Alexander Kovacs may have preferred to be a singer or perhaps a lawyer, his dedication to medicine and his state and county medical societies have thrust him into a big role—191st President of the Medical Society of New Jersey. As a Trenton original, this writer is delighted to see a physician whose origins stem from our state's capitol city "make it to the top."

Doctor Kovacs was born in Trenton, graduated from Hamilton High School in 1942, and matriculated at the University of Pennsylvania. He served as a line officer in the United States Naval Reserve in the South Pacific during World War II. Alex earned his medical degree from the University of Pennsylvania School of Medicine in 1950 and then returned to his hometown to serve a rotating internship at Trenton's Mercer Hospital for one year.

General practice then beckoned, so Alex practiced for a year in the city of his birth, followed by ten years in Plainfield. His heavy load of obstetrics convinced Doctor Kovacs to seek further training, so he studied gynecology at Jersey City Medical Center from 1960 to 1962 and obstetrics at the Margaret Hague Maternity Hospital in 1962 to 1963. He learned his lessons well and was certified by the American Board of Obstetrics and Gynecology in 1967 and was granted Fellowship by the American College of Surgeons.

Doctor Kovacs' organized medical activities have included membership in the American Medical Association, the Union County Medical Society (he served as president in 1974), and successive offices in the Medical Society of New Jersey leading to the presidency. Alex has been a trustee of MSNJ since 1978 and a delegate to the AMA since 1967. He also served as the president of the Plainfield Area Medical Society in 1972 and the New Jersey Physician's Guild in 1973.

Doctor Kovacs maintains offices in Scotch Plains and Dunellen and is senior attending physician in obstetrics and gynecology at Muhlenberg Hospital, Plainfield, and attending at John F. Kennedy Medical Center, Edison. His academic affiliation is with UMDNJ, Newark and Rutgers, where Doctor Kovacs is assistant clinical professor in obstetrics and gynecology.

Alex and his wife, the former Ida Parrey, reside in Scotch Plains. They have three married children—Christine, a medical social worker who lives in Seattle, Washington; Aleda, a teacher of Spanish literature in Barcelona, Spain; and Alex, a real estate appraiser and suburban planner who lives in Orlando, Florida.

Ida and Alex like to travel to Spain to visit their daughter and her family, go skiing, and do gardening. Ida says that Alex's untrained singing voice is much appreciated at home and by his patients in the office and during deliveries. Ida's activities include the County and State Auxiliary, which she serves on the Mental Health Committee, and at the Muhlenberg Hospital where she serves as a volunteer in the admissions office.

We extend our hearty congratulations to Alexander D. Kovacs, M.D., and wish him a successful, happy, and healthy term as the 191st President of MSNJ. A.K.

Orthopods Lead the Way

In a gesture of good will and cooperation, the New Jersey Orthopaedic Society (NJOS) has made an unrestricted grant of $3,000 to the Medical Society of New Jersey. Bernard A. Rineberg, M.D., President of NJOS, presented a check for $1,000, the first of three annual installments, at a recent MSNJ Board meeting.

This generous contribution recognizes the interdependence of medical organizations in our state. The continuing programs of the Medical Society of New Jersey benefit our members, county societies, specialty societies, and the general and medical communities of New Jersey. There are many activities that cannot be accomplished successfully by the smaller county and specialty organizations.

The New Jersey Orthopaedic Society has expressed its appreciation of the general activities and programs of the Medical Society through this gift. MSNJ, in return, has expressed its thanks to NJOS in a resolution that was submitted to the House of Delegates. The resolution accepts the contribution "as a recognition of the common interest and efforts of these two respected organizations" and goes on to "extend to the New Jersey Orthopaedic Society its appreciation and continued cooperation on issues affecting the practice of medicine in New Jersey."

We hope that this will be the start of something. Other specialty societies cordially are invited to come before the Board of Trustees to make their own contribution and commitment.

Paul J. Hirsch, M.D.

Pronouncement of Death

In an editorial entitled, "Who Pronounces Death" (April, 1982), we deplored the decision of the State Board of Medical Examiners to amend NJAC 13:35-6.5 (Pronouncement of Death at a Home, Medical, or Nonmedical Facility) to allow a registered professional nurse or a certified medical technologist to make the pronouncement of death when a physician is not readily available. We wondered about the attitude of others on the issue.

One clear and forthright statement ultimately came from the New Jersey State Department of Health. A memo to "all long-term facilities" from Solomon Goldberg, Director, Licensing, Certification, and Standards for the Health Facilities Services Program, dated September 10, 1982, stated the following:

> The Board of Medical Examiners amended their rules and regulations concerning the pronouncement of death. They have decided that a nurse or a paramedic may pronounce "death" in certain circumstances.
>
> I was called by a physician at a nursing home who advised that the facility was being cited for violating the Manual of Standards for Long-Term Care Facilities regulation that death be pronounced by a physician (section 6.6.7.1). This occurred after the Board of Medical Examiners changed its regulations. He indicated than he was told by the Board of Medical Examiners that its change also was applicable to nursing homes.
>
> This is to advise you that the Department of Health's requirement that death in a long-term care facility be pronounced by a physician remains in effect and was not affected by the Board's action. The Board of Medical Examiners has jurisdiction only over the practice of medicine and not health care facilities.
>
> At this point in time, only a physician can pronounce a patient dead in a long-term care facility. The facility would be found in violation of licensure regulations were death to be pronounced by a person other than a physician.

This issue makes one wonder to what extent the Stat Board of Medical Examiners exceeds its legal authority i other areas which go unchallenged.

A.K

A Good Idea

Young people select medicine as a career for a variety of reasons—exposure to a physician family member or close friend, to a personal physician who serves as a role model, or to television and films where physicians and procedures are shown in romanticized or real-life situations. With the cost of a premedical education in terms of dollars and time expended and the limited number of medical school places available, premedical college students need all the help they can get.

In this issue of *The Journal* (page 421), Alexander et al. described a summer program designed to orient the premedical student to medicine and to the functions and activities in a community hospital. It is a great idea, which apparently was carried out by the author to the satisfaction of all those persons involved.

Students indeed may have their dreams of a career reinforced by such a real-life experience. Although not a hands on situation, for which they are not qualified by training, a closeup look at many aspects of hospital life, including medicine, nursing, administration, laboratory, and rehabilitation, should prove to be a strong influence in the students' decision-making process. However, the student who is interested in the health sciences, but not necessarily prepared for the high cost of time and money for the study o medicine, may veer into an allied health field and save himself or herself a good deal of upset.

Other hospital staffs and administrators in New Jersey should consider this type of program as a community service to a very important group of young people at a critical time in their career planning.

A.K

Definition of Death

Modern medicine has the technical capability to sustain biologic functions of persons who have suffered irreversible cessation of brain function. Recognizing that physicians would be faced with the difficulty of declaring when patients were dead, the AMA House of Delegates, in 1974, adopted a policy (Resolution 77-A74) that declared: "Permanent and irreversible cessation of function of the brain constitutes one of the various criteria which can be used in the medical diagnosis of death." This policy is adhered to by the Medical Society of New Jersey.

The question of when death occurs particularly is significant for several reasons. The emotional trauma suffered by the family and friends of a patient who has developed cerebral damage resulting in "brain death," but who is being technologically sustained, is a dreadfully painful and permanent experience. The financial drain on the family and the health care system is a factor that must be weighed carefully. The potential supply of transplantable organs can be impacted dramatically by the determination of brain death.

Physicians have accepted the fact that death occurs when there is irreversible cessation of all brain functions, including the brain stem. In order to develop a logical and consistent definition of general applicability, the AMA, the American Bar Association, and the Commissioners on Uniform State Laws developed a model bill on the determination of death. Senator John Russo introduced a version of the model bill (S-140) into the New Jersey Legislature. The Medical Society of New Jersey actively is supporting S-140, the Uniform Determination of Death Act, but the New Jersey Hospital Association is opposing the measure.

S-140 provides comprehensive bases for the determination of death in all cases. It codifies the common law concept of total failure of the cardiorespiratory system while, at the same time, it recognizes that artificial means of support may preclude a determination of death under cardiorespiratory failure, but that death can be determined by an alternative definition—irreversible function of the entire brain. The act does not set the criteria for brain death. Instead, it allows those determinations to be made in accordance with accepted medical standards. This means that the medical profession will be able to formulate the necessary criteria and to utilize new and appropriate biomedical knowledge, diagnostic tests, and equipment in reaching its conclusions. In July, 1981, a special Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research** recommended that all states adopt the uniform act.

Medical staffs and hospital trustees run considerable legal exposure on issues such as the determination of death and the continuance or cessation of artificial life support systems. The demand for essential services, the increasing age of our population, and the intense pressures for cost containment and resources allocation are increasing the potential for litigation aimed at hospital trustees and physician medical staffs.

An additional consideration for hospital trustees is the potential of hospital liability for failure to establish the time that death occurred. *The Hospital Law Manual, Attorneys Volume II,*** in the discussion of this very factor, points out that certain business relationships and insurance payments can be altered dramatically by the factual determination of the exact time of death. The legal exposure can be minimized by the enactment and implementation of S-140.

The New Jersey Hospital Association cites the existence of the Quinlan Guidelines as one of the reasons for opposition to this legislation. These Guidelines, however, are not issue dispositive (satisfy the question raised to an accepted degree of legal certainty) since they only come into play after a patient falls into coma, is in a noncognitive state, and is receiving circulatory and/or respiratory assistance. Under the Quinlan Guidelines, the issue is not whether the patient is dead, but whether certain treatments or aids to a patient with only the brain stem functioning should be continued or withdrawn.

CONCLUSION

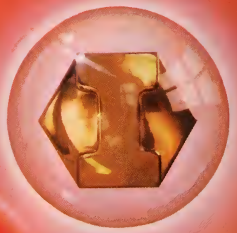
While it is assumed by many that common law would recognize the propriety of a medical determination of brain death, in our state we do not have a sound case on point. We should avoid the uncertainty of the case-by-case approach of the common law. S-140 is desirable and necessary legislation, and warrants the support of the Medical Society of New Jersey and the New Jersey Hospital Association.

*The material for this column is coedited by Arthur Krosnick, M.D., Editor, *The Journal,* MSNJ; Vincent A. Maressa, Executive Director, MSNJ; and James E. George, M.D., J.D., Director of the Department of Professional Liability, MSNJ.

**The President's Commission was created by Public Law 95-622.

***Hospital Law Manual,* Health Law Center, Aspen Systems Corporation, 1982.

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References: 1. Traub, Y. M., *et al.*: Clin. Pharmacol. Ther. *28*:765 (Dec.) 1980. 2. Hollifield, S.W., and Slaton, R.E.: Acta Med. Scand. *647* (Suppl.):67, 1981. 3. Cohen, J.D.: Propranolol vs. diuretics in initial therapy for hypertension. Medical Education Programs Ltd., Ayerst Laboratories, 1982.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

Inderal® (propranolol hydrochloride)

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG.

CONTRAINDICATIONS

Propranolol hydrochloride is contraindicated in 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely; a) if cardiac failure continues, despite adequate digitalization and diuretic therapy propranolol therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levarterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (*e.g.* , CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bron chodilation produced by endogenous and exogenous catecholamine stimulation of bet receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Because of its beta-adrenergic blocking activity propranolol may prevent the appearance of premonitory sig and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is espec important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY: The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires the possible risk to mother and/or fetus be weighed against the expected therapeutic b fit. Embryotoxic effects have been seen in animal studies at doses about 10 times the m mum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action of t drug may then produce an excessive reduction of the resting sympathetic nervous activ Occasionally the pharmacologic activity of propranolol may produce hypotension and/ marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impa renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypot sion; paresthesia of hands; arterial insufficiency usually of the Raynaud type; thrombocy nic purpura. *Central Nervous System:* lightheadedness; mental depression manifested insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointest* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mes teric arterial thrombosis, ischemic colitis. *Allergic:* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and res tory distress. *Respiratory:* bronchospasm. *Hematologic:* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous:* reversible alopecia. Oc mucocutaneous reactions involving the skin, serous membranes and conjunctivae repo for a beta blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings:* Elevated blood urea levels in patients with severe hea disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS

—Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted "INDERAL 10," contains **10 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-0-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-95

—Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted w "INDERAL 20," contains **20 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-9

—Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted "INDERAL 40," contains **40 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-9

—Each hexagonal-shaped, pink, scored tablet is embossed with an "I" and imprinted w "INDERAL 60," contains **60 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-81) and 1,000 (NDC 0046-0426-91). Also in unit dose package of 100 (NDC 0046-0426-9

—Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted "INDERAL 80," contains **80 mg** propranolol hydrochloride, in bottles of 100 (NDC 0046-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-9

The appearance of these tablets is a trademark of Ayerst Laboratories.

Store at room temperature (approximately 25° C).

INJECTABLE

—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).

Store at room temperature (approximately 25° C).

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

8229/383

NAUGURAL ADDRESS

The Practice of Medicine*

ALEXANDER D. KOVACS, M.D., Scotch Plains

You have done me a great honor by electing me as your President for the coming year. One year is a very short time. The days tumble past in dizzying succession. There is so much to do and so little time. So I pose to you a rhetorical question, "What can one person, faced with the enormity of this task, hope to accomplish in one year?"

Since the question is rhetorical, I will supply my own answer—nothing. One person can accomplish nothing.

But the President of the Medical Society is not a single individual. I am you and you and you. I am an obstetrician, an orthopedist, a urologist, and a cardiologist. I am Scotch Plains, Hoboken, Atlantic City, Pennsauken, Newark, and Newton. I am 9,000 men and women and I can accomplish as much or as little as my 9,000 component parts desire.

Do not for one moment assume that you can leave here on Monday and say, "Well, that's over for another year. The 100 or so physicians gathered in this room are the very heart of the medical profession in New Jersey. All of you are the voices and the consciences of those 9,000 physicians. You are their eyes and ears. A delegate to this convention is chosen because he or she is known and trusted by our colleagues to come here and speak, not for three days but for a year—that same short precious year in which I am to speak for you and will be as strong or as weak, as cautious or as bold, and as wise or as foolish as you wish me to be.

Too often in the past, the rank and file of the medical community has distinguished itself by thundering silence. Too often, we have paid no attention to little problems only to find ourselves steamrollered by a big problem.

Everyone in this room has a job to do. You have been chosen as I have been chosen—to lead. Go to your hospital staff meeting—hear what your colleagues have to say. Make sure you belong to and are involved with at least one civic organization so that you become familiar with what other people, nonphysicians, are thinking. Make sure that each and every one of you is a personal friend of at least one state legislator. If you don't know one, get to know one. Have a "Be Kind to Your Assemblyman" day once every couple months. Invite him to lunch or dinner—find out what's on his mind and tell him what is on yours.

Bring all that accumulated information back to your county medical societies, to your trustees, and to me.

In that way, we can keep abreast of what is happening out there before that well-known organic waste hits the proverbial circulating propellors.

Speaking about legislators, we have been through a wild and woolly year. Every group even peripherally connected with health care has decided to get a license. This was the year they all decided to practice a little medicine on the side—audiologists, optometrists, physical therapists, social workers, acupuncturists, and hypnotists. During the past year, all of these groups have put bills in the New Jersey Legislature that would have permitted them to practice medicine in one form or another. If each and every one of you had been in a position to call your local Assemblyman, our job would not have been so tough.

There are hundreds of pieces of legislation introduced each year which impact on this profession—literally hundreds. They are all introduced by someone in the Legislature. The time to stop a bad bill or get a good bill in is before it is written. If your Assemblyman knows you well enough to be comfortable picking up the telephone and asking his physician friend for advice, he might not sponsor an ill-conceived bill in the first place. This would allow us to save our energies for the fights we have to carry out—active, not reactive fights. It certainly will cut down on the proliferation of useless paper. Who knows, we might even save a few trees from extinction!

Remember, too, that the ancillary professions are important to good medical practice. We could not do our jobs without nurses, physical therapists, or medical assistants. They have a legitimate place in health care and physicians and medical societies should not ignore that fact. They are interested in the welfare of your patients. We should not be their antagonist—we don't have to be afraid of them. Perhaps our failure to acknowledge their achievements and their contributions to our success as physicians has been at least partly responsible for their determination to establish their own identity. Have you hugged your physical therapist today?

The ominous shadow which has hung over us this past year has been "competition." What is competition? First, we have to define what we are competing with. Are we competing with ancillaries? If a patient wants to be delivered by a midwife instead of an obstetrician, that surely is her privilege. We know that the vast majority of patients prefer medical care from a physician. What we have here are perennially dissatisfied patients who are looking for nirvana. These patients in many cases would not be satisfied with our efforts anyway. They approach physicians with hostility and end up suing them. The easy way is to say, "Go and good riddance—you and your pseudo-physicians deserve each other." However, we always must keep in mind that these patients, as annoying as they might be, someday may have a real need for our kind of care so we must offer such help when they finally turn to us.

*The Inaugural Address was presented before the House of Delegates, April 30, 1983, Resorts International, Atlantic City.

What I am trying to tell you is to make a distinction in your mind between true competition and insults to your vanity. As an obstetrician, I cannot help feeling angry when a patient prefers a midwife to me. My ego is at stake here. My "God complex" is damaged. And yet, was it my "God complex" that drove that patient away in the first place? Am I still taking the easy way out with my patients—patting them on the head and saying, "Don't worry about a thing. Big Daddy will take care of you." This is an era of patient sophistication. They read, listen to television, and are subject to a barrage of information and misinformation. They have a new awareness of their right to know. We are foolish if we do not respond to that. It takes longer to discuss your treatment with a quasi-informed patient but you both will be happier in the end.

What is it that our ancillary competitors give patients that we do not? It is not greater skill; it is not greater technology —it is large doses of TLC—tender loving care. It is a willingness to associate with that patient as a human being. It is time and respect for their intelligence. We must make some small adjustments in our schedules to accommodate them by having office hours occasionally in the evening or on a Saturday. We should have the courtesy to schedule appointments so that a patient does not sit in our office for two hours receiving the nonverbal message that our time is more valuable, sitting there getting more angry with us by the minute. In short, it is respect for that patient as a human being that the ancillary competitor offers and that we, all too often, fail to give.

We are superior in every way to that kind of competition except that we sometimes do not show we care. If we can change that, we can win this fight no matter how many bills are passed or how many licensing boards are set up. As the golden rule states: Do unto others as you would have others do unto you. Simple, but it works.

The other kind of competition we worry about is from within—competition between the salaried physician and the private practitioner. There has been a tremendous proliferation of hospital-based satellites, ambulatory health care centers, emergency care centers, and hospital-based physicians. I am a private practitioner so I tend to get irritated about this. I get irritated about salaried HMOs. I get irritated by anything that threatens to impact upon my world. And yet, who are these competitiors? Not people less qualified than I am. They are people just as well trained. Are they my enemy? No, they are my peers and I must be as willing to compete with them as with any other private practitioner. They may have certain economic advantages. They usually do not have office overhead or payrolls to meet. In some cases, they do not have to pay their own malpractice insurance—they do not have to worry about collections. With all these advantages, their take home pay is the same as mine—sometimes better. But what they gain in economic advantage, they tend to lose in the freedom to be their own person. That is their choice and part of the price they pay for some sort of economic security. Remember one thing—they can be fired. No one can fire a private practitioner except the patients. And, most important, remember this. They are physicians. They are physicians of talent and skill who have chosen a different method to deliver their services. Now, this is competition I can respect. They are members of this organization because as physicians they have a right to be here, a right to be heard, and a right to share in the decision-making processes of this organization.

We cannot go back to the days when private practice was the only option. I say to you—these are our peers. We have more in common with them than we have in contention. Let us not make the fatal mistake of drawing battlelines among ourselves. There is no one way to practice good medicine. You can be a solo practitioner, part of a group, in an HMO, or a salaried physician in a hospital, industry, or research. We all contribute to the public good. We all serve our patients and our profession.

We must not allow ourselves to fall victim to the one disease that can destroy us. We must not fight among ourselves. While we can and should disagree philosophically because such disagreement brings about progress, we must not become divided on the principles of medical practice.

It was true when Lincoln said it and it is true today. A house divided against itself cannot stand. We must stand together proudly as a profession united against the assaults of those less capable who want to do what only we are trained to do—against the assaults of an intrusive government attempting to nationalize us into a slave industry to be distributed where and how they choose and paid whatever stipend they decide is proper and against the media which portrays us as sex-crazed clowns on soap operas and money hungry incompetents on the evening news.

This is not to say that we do not have among our numbers some money hungry incompetents. We may even have a few sex-crazed clowns. But we do try to root them out and I believe we do a far better job of it then the world recognizes. We do it in our medical societies and we do it in our hospitals. We do it where it counts. We just don't do it in the newspapers.

Maybe we do not brag enough about the good things we do. Maybe we should tell people how we fight for quality care in our hospitals and quality ethics in our societies. Maybe we should tell people about the patients we all treat for nothing, about the bills we don't even try to collect, and about the free services we all donate to our clinics. Maybe we ought to stop being so modest. Maybe we ought to have our medical society do television commercials for us like that pretty actress does for hair dye when she says, "Sure, it costs more, but I'm worth it."

As I said before, there is more than one way to practice and that is true in the context I have outlined. In a larger sense, however, there is only one way to practice—the right way. Above all, practice good medicine. The slings and arrows of those who wish to oppress us cannot prevail except if we fail in this one thing.

And don't get discouraged. Doctors have been fighting for respectability since the profession began and you know who made it respectable. We did—not any outside agencies. It was physicians who insisted on accredited medical schools. It was physicians who fought for testing before licensure. It was physicians who did the research which brought about life-saving technological advances. It was and remains physicians who insist on the best, and nothing but the best, in health care for the people of this country.

I accept the leadership of this Society with pride—I am proud that you have chosen me because the respect of this group is the greatest honor any person can hope to achieve. I am proud of you—your dedication, your courage, and your professionalism. You have honored me and, in turn, I honor you. You are the best of the best. In a profession marked by distinction, you have been chosen by your peers to be here today. They have, with good reason, put their trust in you. You have seen fit to put your trust in me. God willing, with your help, I shall be worthy.



COMING SOON

THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD

WITH THE SIMPLICITY AND CONVENIENCE OF ONCE-DAILY DOSAGE

NEW INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

THE ONE TO COUNT ON

The appearance of Inderal LA capsules is a trademark of Ayerst Laboratories.

Please see next page for brief summary of prescribing information.

ONCE-DAILY INDERAL® (PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg 120 mg 160 mg

BRIEF SUMMARY

(For full prescribing information, see package circular.)

INDERAL® LA brand of PROPRANOLOL HYDROCHLORIDE

(80 mg, 120 mg, 160 mg Long Acting Capsules)

DESCRIPTION. Inderal LA, a formulation to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It competes with beta-adrenergic stimulant agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upward should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been found therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product INDERAL LA can produce greater beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of the sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection duration. The prolonged effect of beta-receptor blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In addition, other than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential The significance of the membrane action in the treatment of arrhythmias is uncertain

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the increases in AV conduction that sympathetic activity ordinarily produces. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm

Propranolol is not significantly dialyzable by conventional techniques.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. At the first sign or symptom of impending heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases has been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. General Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease alleviated with transient beta blockade phosphatases, lactate dehydrogenase,

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any the dosage levels used Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy Pregnancy Category C INDERAL has been shown to be embryotoxic in rats at maternal doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman

Pediatric Use. Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular bradycardia, congestive heart failure, intensification of AV block hypotension, paresthesia of hands, thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type

Central Nervous System Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations, alterations in sense perception, reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium and decreased performance on neuropsychometrics

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory bronchospasm

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Autoimmune In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of 640 mg may be required The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS)

MIGRAINE—*Dosage must be individualized* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a trademark of Ayerst Laboratories **8520/582**

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

FAREWELL ADDRESS

A Time of High Adventure*

HOWARD D. SLOBODIEN, M.D., Metuchen

This past year has afforded me the time of my life. There have been occasional frustrations, but—by and large—I have been challenged and rewarded beyond measure. I don't know that I can say the same for my partner and for my wife, who have given of themselves to free me for this task. Sally has been the gracious First Lady, par excellence, in our various travels as representatives of this prestigious Society. I thank them both from the bottom of my heart.

Last year I spoke of the external forces besetting us. They were there, as you can tell from my official report, and I have alluded at them throughout the year. At best, I may have allowed their motion a trifle, but you can be sure their activities will continue.

It has become more and more apparent that government, in all its ramifications, is the number one problem to the medical profession. There is a certain amount of irony in this situation. In all the polls the physician is considered a member of the most honorable and respected occupation or profession. Conversely, when the question is asked, "What are the three greatest lies?"—regardless of what any two of the answers may be—the third lie always is, "I'm from the government and I'm here to help you." Oh, how the media have tended to change savior into villain and villain into savior! All three branches of government participate in the process—the courts to some extent, and the legislative and executive branches to the point of rebellion.

It is upsetting to have lesser-skilled paraprofessionals raised to levels unwarranted by their training. It is troublesome to have reasonable attempts at reforming tort law frustrated by power blocs. It is unnerving for Big Brother to be looking over one's shoulder and monitoring even the most inconsequential of physician activities. It is unfair for bureaucrats and legislators to attempt to fix physician reimbursement as add-ons to regulations and statutes. It is unwise for legislators to mandate ethics before meaningful dialogue has occurred. It is foolhardy for government to alter radically the payment for health care in favor of an untried system. It is unjust, in this age of competition, for certain deliverers of care to be given uncompensated advantages against others in the system.

And, it is intolerable for all of these constricting and restricting actions to be promulgated and instituted without the proper involvement of the medical profession. Yet, such is the case. Two hundred years ago this country heard the battle slogan, "Taxation without representation is tyranny." Perhaps it is time for us to renew that slogan, with or without another tea party. Certainly, this is the time for all nonparticipating medical practitioners to understand these problems and to join with those already in the fray. We cannot afford a large body of noncontributors; we cannot afford a divided house.

But now the time has come for me to step aside; youth must be served. This Society is blessed with an unending supply of talent. Alexander Kovacs is one of those most talented and he is sure to surpass my puny efforts. In his task, I know he also will have the unswerving support of those who have so nobly aided me—Vincent, Marty, Joe, Arthur, Ron, Dave, Diana, Marie, Kathleen, June, and all the others at headquarters as well as the members of the Board and especially its Chairperson, the chairman and members of councils and committees, Linda Hirsch and the Auxiliary, and all of you, who have given me what Bill Rial and Dan Cloud have termed, "a time of high adventure." If I can continue to serve Alex, his successors, and this Society, rest assured I shall do so.

You have given me one of the best years of my life. For this I say "Thank you, thank you, thank you."

*Presented before the House of Delegates at the Annual Meeting, April 30, 1983, Atlantic City.

Gale Wayman, President

Gale Glendinning Wayman is the 57th President of the Medical Society of New Jersey Auxiliary. Gale assumed leadership of the Auxiliary on May 1, 1983, at MSNJ Auxiliary's Annual Meeting.

Gale graduated from Hamilton High School and attended Trenton State College as a business education major. She then spent two years in Arizona, working for the Post Office in Tombstone and the Army at Fort Huhchuca.

With her family, Gale returned to New Jersey in 1962, and worked at the Western Electric Research Center, Princeton, in accounting and public relations. While working, Gale attended evening classes in business and education, and in June, 1970, she graduated from Trenton State College with a degree in English education. Gale is a licensed realtor on Long Beach Island, and is public relations consultant for Mercer County Medical Society.

Gale and B. Ralph Wayman, Jr., M.D., have two sons: Scott, age 23, and Ralph III, age 19. Scott graduated from Rider College, Lawrenceville, last June with a degree in marketing, and Ralph is a premed student at Muhlenberg College, Plainfield.

As a member of the MSNJ Auxiliary Executive Board, Gale has served as: Hospitality Chairman; liaison representative to Volunteer Friendly Visitors; Corresponding Secretary; Legislation Chairman; Second Vice-President; First Vice-President; and President-Elect.

Gale's community activities include membership in the Mother's Club of the Pennington School, Planned Parenthood of Upper Makefield, Helene Fuld Medical Center Auxiliary, and Secretary of the Zoning Hearing Board of Lower Makefield Township.

We wish Gale Wayman a successful year as President of the Medical Society of New Jersey Auxiliary. G.H.



Gale Glendinning Wayman

GOLDEN MERIT AWARDS

At ceremonies held on April 30, 1983, during the 217th Annual Meeting of the Medical Society of New Jersey, at Resorts International, Atlantic City, the following members received MSNJ's Golden Merit Award indicating 50 years of medical practice.

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REFER TO PDR

A Community Hospital's Program for Premedical Student Orientation

STEWART F. ALEXANDER, M.D., MICHAEL A. NEVINS, M.D.,
LEONARD J. LYON, M.D., HELEN S. THAYER, LOUIS R. YCRE, JR., Westwood*

Premedical college students seek hospital summer employment to aid them in career planning. An education program in a community hospital exposed a group of students to the broad spectrum of medicine and hospital care. The students and the medical, nursing, and administrative staffs concluded that the course was successful. We recommend that similar programs be developed.

Each summer many premedical college students seek positions in hospitals in the hope of gaining experience, or at least some exposure, to the world of medicine. However, most of the few jobs that are offered are subprofessional, e.g. orderlies, nurses' aides, stretcher transporters, or clerks. These positions fail to provide a learning opportunity and may be a waste of the time of these talented young people.

After several years of attempting to respond to increasing numbers of requests from students for summer employment, we decided that instead of offering summer jobs of limited scope, we would organize a course that would permit premedical students to familiarize themselves with a broad spectrum of medicine and hospital care. It was felt the course would provide a unique contribution and a significant community service. Our initial experience shows that such a course readily can be conducted, even in a nonteaching, community hospital and can assist the participating students in making career decisions.

Pascack Valley Hospital, Westwood, is a nonprofit, 242-bed community hospital. There are 198 physicians on the staff, 75 percent of whom are board certified in their specialties. There are no interns, residents, or house physicians.

THE PLAN

The six-week training program was designed to introduce and orient the students to as many facets of medicine and hospital care as possible. A noon-day meal was furnished but no fees were charged and no remuneration given. Selection of students was difficult since a large number of qualified candidates applied despite only minimal efforts at recruitment. We decided to accept only students who were entering their third or fourth undergraduate year and who were from the area served by the hospital. Eventually, six students were selected, one each from Columbia University, Georgetown University, University of Delaware, University of Florida, Princeton University, and Yale University. On reviewing the application forms, we were surprised by the students' perception of a need for advice and guidance as to whether or not they would be suited emotionally or intellectually to pursue a career in medicine. The following quotations are typical: "It's fine to say that I'm interested in medicine, but with no exposure to it I can't be sure"; "Although I'd like to pursue a career in medicine, I have not reached a definite decision as to career plans. I would welcome the opportunity to observe firsthand what medical practice is like in order to see if I am suited to the profession."

The program was divided into one-week assignments as follows: medicine and its subspecialties; surgery and its subspecialties; hospital administration; radiology; laboratory; and physical medicine, rehabilitation, and specialty laboratories.

The students attended an inhouse cardiopulmonary resuscitation course and eventually were certified in those techniques. Additional units of time were spent in the cardiology department, respiratory therapy, sports medicine, pharmacy, medical library, and the emergency room. The students shared lunches together which provided an opportunity to exchange their individual experiences. In addi-

*From Pascack Valley Hospital, Westwood. Correspondence may be addressed to Dr. Stewart F. Alexander, 108 Pascack Road, Park Ridge, NJ 07656.

TABLE

Guidelines for the Major Divisions

- **Medicine**—the role of the primary care physician, the scope of medical practice, types of medical practice, the importance of hospital care, and areas of specialization.
- **Surgery**—the function of surgery in overall medical care, surgical discipline, basic principles of surgical diagnosis, broad principles of surgical therapy, sphere of surgical specialties, informed consent, and how surgical results are appraised.
- **Laboratory**—the importance and relation of the laboratory to clinical medicine, routine procedures, bacteriology, pathology, blood procurement and blood banking, automation, radioisotopes, computers, quality control, cost factors, and laboratory records.
- **Radiology and Nuclear Medicine**—radiology safety, discipline, and training, routine procedures, image intensification, remote control, nuclear medicine scope, future of nuclear medicine, special procedures, radiation therapy, and private radiology practice.
- **Physical Medicine/Rehabilitation**—the role of physical medicine and rehabilitation in overall medical care of inpatients and outpatients, general techniques, psychological factors, speech therapy, occupational therapy, job retraining, and social service.
- **Administration**—hospital functions, hospital government, and governance relation of the hospital to the community, relation of administration and physicians, social service, admission and discharge procedures, nursing care, medical records, fiscal procedures, Medicare/Medicaid, hospital insurance, quality control, computer application, dietary (food procurement, preparation, and delivery), housekeeping, inspections by regulatory agencies, cost factors, role of physician in cost containment, hospital development and planning, security and safety, and transportation.

tion, they met with the course supervisors weekly. Many attended the medical records, utilization, and audit committee meetings as well as clinical pathological conferences and other hospital continuing medical education programs.

All instructors were volunteers from our staff and most of the instruction was on a one-to-one basis. Each department and instructor were furnished with an outline of the kind of material that we considered appropriate and were urged to integrate the students as much as possible into their normal daily routine (Table). We stressed that these directions were to be used only as guidelines and instruction structured so as to encourage the fullest expression of individual interest, both by the instructor and the student.

Each student maintained a complete log of activities and reactions to the events of the day. These logs were maintained in exemplary fashion and ranged from 35 to 59 pages each. At the completion of the course, each student received a certificate of participation and a descriptive statement of the program, which may prove useful during the process of medical school application. A student evaluation form and resume by the teaching staff, together with a photograph of each student, was maintained for future reference.

Although we were apprehensive at first, confidentiality was maintained and intrusion into physician-patient relationships did not prove to be a difficulty. The students were briefed carefully on these matters and the consent of each patient was obtained beforehand by the respective staff physicians. There was no hands-on-contact with patients. Absenteeism was no problem; there was none. Indeed, students at times were found as late as 10:00 P.M. with their physician instructors.

EVALUATION

Objective evaluation of the course is difficult, but an attempt was made to ascertain the viewpoints of the students, the administration, and the medical staff.

The students were most enthusiastic and perceptive. They felt they had undergone a valuable experience that would help them to make more informed judgments concerning their career decisions. They appreciated the fact that they were taken seriously and that busy people were willing and eager to volunteer time in order to communicate with them. Five of the six felt a firmer and better founded commitment to a medical career. One noted that her degree of commitment was even deeper than anticipated but felt that she might be happier in a related health field or in research than in clinical medicine.

Each student was asked to respond in a postcourse questionnaire to both specific and broad inquiries. Sample statements are indicative of the students' reactions: "The course was fabulous"; "Before I participated, I wasn't certain about medicine as a vocation, now I can make an intelligent decision"; "Thanks, it went past what I had expected"; "We got to see a broader view of medicine, perhaps more than anyone else at the hospital could"; "I am much surer of medicine being what I'd like to do, before I had no idea"; "It exceeded my expectations"; "This course has strengthened my desire to go into medicine as a career to a point where I cannot even think of doing anything else."

The administration initially had some reservations about attempting a program of this nature in a nonteaching institution. These doubts were dissipated by the enthusiasm of the students and the administrative department heads. The effect of specific, although limited, course assignments to such areas as security, engineering, and quality control was to stimulate pride and self-expression among employees in these necessary, but often overlooked, hospital sections. The hospital benefited by the demonstration that the administrative, medical, and nursing staffs could work together harmoniously on a unique experiment and by showing the community that the hospital could provide a useful educational service beyond the health function.

A few physicians expressed some initial scepticism but overall the staff participated to a degree far beyond our initial hopes. Evidently, many physicians had a latent desire to teach for which this program offered an avenue of expression. Many felt stimulated by the students' inquiring minds and questions. Nearly 25 percent of the staff participated and, with few exceptions, expressed the hope that they would be included again in the future.

The community's response particularly was gratifying. Local leaders commended the hospital's effort to help local college students interested in medicine and expressed the hope that after a period of years, some of the same students might return to practice in the area.

CONCLUSION

A 6-week summer program was developed in a community hospital in order to expose premedical college students to some of the many aspects of medical and hospital practice. Enthusiastic participation by medical, nursing, and administrative staffs made the program a success and provided a particularly valuable experience for those students in doubt about their commitment to a medical career. We recommend that similar programs be developed so that students with the best talents may be attracted to medicine and health care.

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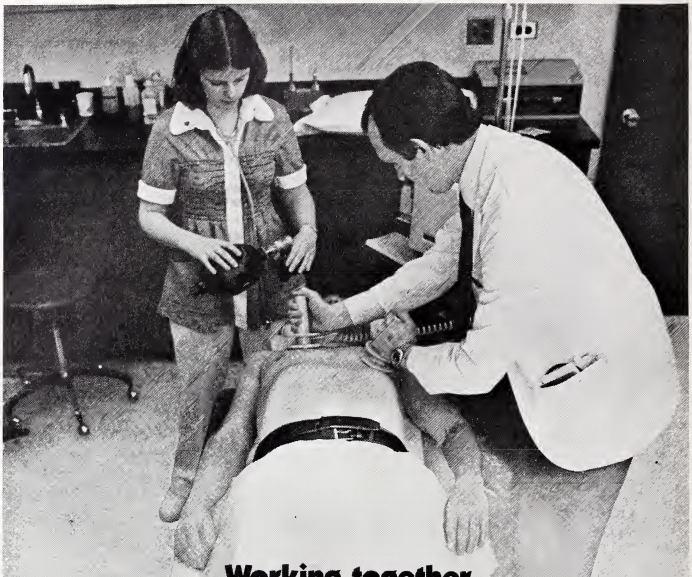
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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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Continuous Ambulatory Peritoneal Dialysis (CAPD)

SHAMKANT MULGAONKAR, M.D., NEIL LYMAN, M.D.,
RONALD VISCUSO, M.D., MARTIN G. JACOBS, M.D., Livingston*

We reviewed our experience with CAPD. In 24 months, 50 patients were trained; currently 24 remain stable on this modality. Blood chemistries were comparable to other forms of dialysis therapy. Diabetic individuals were trained to administer intraperitoneal insulin to enhance blood sugar control. Major problems encountered were peritonitis and hypertriglyceridemia.

Continuous ambulatory peritoneal dialysis (CAPD) is a new modality of peritoneal dialysis described initially in 1976 by Popovich and Moncrief.[1] This procedure began a new era in the treatment of end-stage renal failure.[2-4]

CAPD trades the relatively long dialysis sessions three times a week for several 30- to 40-minute interruptions of daily activities every day. Peritoneal clearances, expressed as ml/min, are low in CAPD; however, because dialysis is continuous, the weekly peritoneal clearance of small molecules such as urea are adequate. CAPD clearance of middle molecular weight substances is higher than with conventional intermittent peritoneal dialysis (IPD) and approximately five times that of hemodialysis (HD).[6]

METHODS

At Saint Barnabas Medical Center, Livingston, we reviewed our experience with CAPD in the past 24 months. A total of 50 patients were trained and currently 24 remain on this modality. The patients were accepted in the program of their choice after they were referred by their physicians. The underlying renal disease was not a contraindication for the selection of a candidate for CAPD. Table 1 shows the patient population on CAPD.

The relative contraindications for CAPD were a small peritoneal cavity, extensive abdominal surgery, severe back problems, and physical handicaps such as obesity, ostomies, disabling limb problems, and blindness. The CAPD solution was made available by Travenol Laboratories, Inc. in plastic bags; its composition is shown in Table 2. There were no added drugs or electrolytes except for the diabetic patients who were trained to administer intraperitoneal insulin.

Initially, a permanent indwelling peritoneal catheter is placed in the peritoneal cavity.[5] Dialysate is instilled into the peritoneal cavity where it is present 24 hours a day, seven days a week, except for the brief periods of drainage and instillation of fresh two-liter solution three to five times a day. After each fresh instillation of solution, the patient folds the empty plastic bag and places it in the cloth pouch around the abdomen. At the end of the dwell period, the effluent is drained into the same bag, the bag is discarded, and a fresh bag is attached to the same tube. This system enables the patient to participate in the usual daily activities thus avoiding machine dependence.

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TABLE 1

*Patient Population On CAPD**

Underlying disease	No.	%
Chronic glomerulonephritis	9	37.5
Diabetes mellitus	9	37.5
Nephrosclerosis	2	8.3
Polycystic disease	2	8.3
Chronic interstitial nephritis	1	4.1
Congenital abnormalities	1	4.1

*24 patients

Peritoneal access was gained by the placement of a Tenckhoff peritoneal catheter under local anesthesia in the operating room. During the initial 24 to 48 hours after insertion of the catheter, intermittent peritoneal dialysis was performed with standard dialysis solution using an automated cycler. Smaller amounts of the solution were used initially to avoid pain and leakage around the catheter. The patients then were trained to perform the bag exchange under aseptic precautions by the renal nursing staff. The total training period averaged ten days but varied from patient to patient. Following adequate training, patients were discharged from the hospital and were seen monthly for tube change by the nursing staff, physical examination by a physician, and blood work. In the event of peritonitis, patients were hospitalized for treatment.

RESULTS

The clinical course of 50 patients trained on CAPD was a follows: patients presently on CAPD: 24; deceased: 6; transplanted: 1; transferred to HD: 13; transferred to IPD: 5; and off dialysis: 1.

The chemical profile of our patients is shown in Table 3. The ultrafiltration obtained with various dextrose solutions has been relatively uniform and was 400 to 600 ml for 4.25 percent, 250 to 300 ml for 2.5 percent, and 150 to 200 ml for 1.5 percent. The average dwell time in the peritoneal cavity was 4½ hours.

Seven insulin-dependent diabetic patients were trained to administer regular insulin intraperitoneally with each dialysis exchange. The mean total daily dose of regular insulin was 106.8 ± 44.8 units. The results of blood sugars obtained on this regimen are seen in Table 4. Blood glucose control was achieved within five ± two hospital days. There was no significant increase in the peritonitis rate in this group.

The peritonitis rate at our center was 17.3 patient weeks/infection with 68 episodes occurring in 1,178 patient weeks. Eleven patients had 3 or more episodes of peritonitis accounting for 62 percent of all infections. Importantly, 7 of 11 patients in this subset had 2 episodes of peritonitis in the first 12 weeks of CAPD. All patients had titanium adapters attached to the distal end of the Tenckhoff catheter, had monthly tube changes by the nursing staff, and used plastic bags. The various microorganisms that were responsible for the peritonitis are listed in Table 5.[7]

A methicillin- and cephalosporin-resistant *Staphylococcus epidermidis* has emerged as an important pathogen in our patients with peritonitis. This has required a change in our treatment protocol of initial antibiotic of choice of cephalosporin or methicillin. In the event of peritonitis, two rapid exchanges are performed and a single loading dose of IM or IV aminoglycoside is administered. Subsequent exchanges are performed by adding vancomycin (30 mg/liter) and aminoglycoside (8 mg/liter), pending cultures. Since gram-negative organisms account for 25 percent of all episodes of peritonitis, aminoglycosides are added empirically until cultures are available. All cases of *Pseudomonas* and fungal peritonitis required removal of the catheter for cure. Fungal peritonitis was treated with parenteral amphotericin B following removal of the catheter. An indwelling subclavian access as described by Uldall obviated the use of Scribner shunts and repeated femoral cannulations for hemodialysis when peritoneal access was temporarily removed.[8]

Protein losses during and one month following peritonitis were greater than preperitonitis values in two patients studied as shown in Table 6. The major cause of CAPD failure was peritonitis although change in body image especially in patients with polycystic kidney disease, catheter failure, respiratory insufficiency and rarely lower extremity gangrene, ventral hernia, and diminished peritoneal clearances also were seen. The causes of death in six patients who expired while on CAPD are shown in Table 7.

DISCUSSION

These studies at our center are comparable to most major centers involved in continuous ambulatory peritoneal dialysis.[9,10] The chemistries obtained on a regimen of four exchanges/day are similar, if not better than other available dialysis modalities.

A significant number of our patients were diabetic individuals (37.5 percent). Since CAPD utilizes capillaries of the peritoneum as blood path, there is no anticoagulant necessary, thus minimizing the risk of retinal hemorrhages in this population. Also, the efficient removal of middle molecules may be useful in retarding the neuropathy in diabetic individuals with end-stage renal disease.[11]

TABLE 2

Peritoneal Dialysis Solution
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	With 1.5% dextrose	With 2.5% dextrose	With 4.25% dextrose
Dextrose H_2O	15 g/l	25 g/l	42.5 g/l
Sodium	132 meq/l	132 meq/l	132 meq/l
Calcium	3.5 meq/l	3.5 meq/l	1.5 meq/l
Magnesium	1.5 meq/l	1.5 meq/l	1.5 meq/l
Chloride	102 meq/l	102 meq/l	102 meq/l
Lactate	35 meq/l	35 meq/l	35 meq/l
Total osmolarity	347 meq/l	398 meq/l	486 meq/l
Approximate pH	5.5	5.5	5.5

TABLE 3

Laboratory Data

	>8 mos (n = 10)	<8 mos (n = 14)
Creat mg/dl	11.6± 3.9	11.8± 4.2
BUN mg/dl	71.9± 24.5	69.4± 20.7
Phos mg/dl	5.6± 1.3	5.1± 1.4
Calcium mg/dl	8.8± .9	8.9± 1.1
Alk phos μ/ml	139.3± 102.0	104.9± 57.6
U.A. mg/dl	6.3± 1.6	7.9± 1.4
Alb g/dl	3.5± 0.7	3.5± 0.5
Chol mg/dl	301.4± 280.8	225.9± 98.9
Trig mg/dl	207.7± 75.6	378.8± 277.5*
HGB g/dl	8.9± 2.3	10.0± 2.2
HCT vol%	27.5± 7.0	30.1± 6.2
Na meq/l	140.0± 2.6	137.1± 5.8
K meq/l	4.4± 0.9	4.6± 0.6
Cl meq/l	101.0± 3.1	97.1± 5.4
HCO_3 meq/l	22.5± 2.7	23.1± 3.2
Gluc mg/dl	146.1± 75.8	194.2± 128.5

*$P<.05$

TABLE 4

Mean Serum Glucose: Intraperitoneal Insulin

	Glucose (mg/dl)
Fasting	142.8±60
Exchange and meal	
1 hr postprandial	179.8±93
2 hr postprandial	202.9±69

*7 patients, n = 28; mean ± S.D.

TABLE 5

Causative Organisms

	%
Staphylococcus epidermidis	46
Streptococcal species	18
Staphylococcus aureus	7
Pseudomonas species	7
E. coli	7
Enterobacteriaceae	6
Flavobacterium	4
Bordetella bronchiseptica	5
Candida albicans	5
Torulopsis glabrata	5
No growth cultures	5

TABLE 6

CAPD Protein Losses Due to Peritonitis (P)

(4 exch/day; 2.5% bags) N=2 patients

	Pt. without P	Pt. with P	ì mo. s/p P
Gms/day	7.5±1.1	10.3±1.6*	9.6±.8*

*$P<.05$

TABLE 7

Deaths on CAPD

Cerebrovascular accident	2
Myocardial infarction	4
Cardiogenic shock	1
Sepsis	1
Unknown	1

Other problems encountered were:

Control of serum glucose. We trained our patients to administer intraperitoneal insulin instead of a single dose subcutaneous NPH insulin in the morning. The results obtained show that the blood sugars can be well controlled with this technique.[12,13] The incidence of peritonitis with this method has not changed.

Hypertriglyceridemia. Hypertriglyceridemia is a major problem in all uremic patients on CAPD and diabetic patients are at a higher risk.[14] Our experience so far suggests that, besides diet, exercise, and intraperitoneal insulin, in diabetic patients there is no effective and safe agent available to control triglycerides.

Blindness. A blind diabetic patient was successfully trained to perform CAPD at our center and remained on this modality for 12 months with only one episode of peritonitis. She has since received an allograft and is dialysis independent.

Peritonitis. The major disadvantage of CAPD is peritonitis. There are various organisms responsible (Table 4). Patients with repeated episodes of peritonitis can be recognized early in their course of peritonitis, as seen in the data presented. Eleven patients had three or more episodes of peritonitis accounting for 62 percent of all infections and 7 of 11 patients in this subset had two episodes of peritonitis in the first 12 weeks of CAPD. These patients should be encouraged toward other forms of dialytic therapies. The emergence of cephalosporin-methicillin resistant *Staphylococcus epidermidis* at our center was a major concern since it still remains the single most common organism responsible for peritonitis. Our approach is to treat these patients with vancomycin and aminoglycoside.

Peritonitis due to *Pseudomonas* species and fungi is extremely difficult to eradicate and requires the removal of the Tenckhoff catheter for cure in a majority of cases. These patients subsequently need therapy with appropriate parenteral antibiotic. We have utilized the indwelling subclavian cannula as access devised by Uldall for hemodialysis when peritoneal catheters are temporarily removed. This has obviated the use of Scribner shunts and femoral vein cannulations. Adequate nutrition should be encouraged due to the ongoing protein losses that occur during and following an episode of peritonitis. We have trained all our patients in the hospital and can frequently predict the patients who will fail on this technique.

CONCLUSION

CAPD is a very useful modality in the treatment of end-stage kidney disease, but should be employed carefully. The major advantages offered by CAPD are the liberalization of diet, steady state of chemistries, minimal cardiovascular stress, and no blood losses. The important disadvantages of this form of therapy are peritonitis and lipid abnormalities. A search for control of these two problems with the use of a bacteriological filter[15] and substitute dialysate[16] is required.

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Colposcopy Practice Among Obstetricians and Gynecologists

LEAH Z. ZISKIN, M.D., and
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The responses of 279 New Jersey obstetricians and gynecologists surveyed about their training and experience in the utilization of colposcopy were analyzed. The results indicated that 51.6 percent of the respondents followed their patients with colposcopy for abnormal Pap smears and 77 percent of those who did not practice colposcopy referred their patients for colposcopic examinations.

Passage of P.L. 1981 Chapter 288 by the New Jersey State Legislature charged the State Department of Health with establishing a program to address the needs of individuals exposed to diethylstilbestrol (DES). The Department of Health was concerned about these special individuals and also was interested in the broader problems of the management of patients with abnormal Papanicolaou (Pap) smears. In October, 1978, the National Cancer Institute awarded the state a contract that provided funds for the referral and followup of women who were considered at risk for carcinoma of the cervix. This target population was defined as women who were over 40 years of age, who had never had Pap smears, who were sexually active at an early age, or who had a diagnosis of venereal disease. This project provided an opportunity to review the medical management of 22,343 women receiving Pap smears, 684 (3.1 percent) of whom had nonnegative Pap smears.

Because of this experience, Cancer Control Program personnel thought it important to assess the need for and accessibility to colposcopic examinations for women in New Jersey. This needs assessment was to be determined in the private practice of gynecology and in publicly supported gynecology services for the following major reasons:

- The inconsistent use of colposcopy in the management of nonnegative Pap smears.
- The publicity and inconsistent directives given to physicians on the need for colposcopy in the management of "DES daughters."
- The feeling of experienced colposcopists that too many physicians were performing infrequent colposcopic examinations and that this may have resulted in mistreating and/or overcharging the patient.[1]

The Department of Health brought these concerns to the Council of the New Jersey Obstetrical and Gynecological Society and obtained the Council's endorsement and concurrence as to the need for such an assessment. It was agreed that the Council and the Department would collaborate on obtaining the information necessary to assess the problem.

Colposcopy was developed in 1925 by Hinselmann. Colposcopy is a diagnostic technique that examines the surface features and vascular pattern of the cervical and vaginal epithelia. It is an adjunct that links Pap screening and definitive histologic diagnosis; however, it certainly should not be considered as a replacement for either. Colposcopy permits an accurate assessment of the extent of epithelial changes on the cervix and vagina, and can be used as an aid to detect those areas most likely to disclose abnormalities on biopsy.[2] It follows that for many patients, the cost and morbidity of conization and hysterectomy performed both for real disease and for marginally unfavorable cytologic findings can be reduced, if not eliminated.

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However, a major disadvantage to using colposcopy is the difficulty in acquiring the necessary skills.[3] As with any technique, the proficiency of the performer is dependent upon training and continued practice. Because colposcopy is an active procedure that requires immediate interpretation of what is being observed, it would be prudent for training to consist of more than a lecture series with slides. Quality training should include a chance for the trainee to examine patients under the direction of a trained colposcopist with a discussion of what both observe simultaneously.

MATERIALS AND METHODS

The Council of the New Jersey Obstetrical and Gynecological Society and the New Jersey Department of Health (NJSDH) cosponsored a survey of all New Jersey Obstetrical and Gynecological Society members in 1980 to assess the need of gynecologists to receive more education in the management of patients with abnormal Pap smears and in the management of patients exposed to diethylstilbestrol (DES) in utero. The Council of New Jersey Obstetrical and Gynecological Society and the New Jersey Chapter of the American College of Obstetricians and Gynecologists identified those practitioners considered "expert" colposcopists. Designation as "expert" was based on peer judgment among those physicians who were experienced in gynecologic oncology and performed a minimum of nine colposcopic examinations per month, at least 90 percent of which were on patients referred to them by other gynecologists.

The survey was designed to obtain information on the physician's training and experience with the colposcopy technique itself. The Department developed a questionnaire that was mailed to the 491 obstetrician/gynecologists on the roster of the Council of the New Jersey Obstetrical and Gynecological Society. A total of 279 (56.8 percent) analyzable responses were received; in addition, one survey was returned after the cut-off date for analysis; five were returned due to invalid addresses and 21 responses indicated that the physicians were no longer practicing (retired or deceased).

Confidentiality was maintained by using numeric codes and keeping the numerically coded mailing list in a separate file. The numbering system was considered necessary so that results of the general respondents could be compared to the responses obtained from the practitioners designated as "expert" colposcopists by the Council of New Jersey Obstetrical and Gynecological Society.

All responses were reviewed before computer processing to assure that survey instructions were followed. Inconsistent responses were changed to "unknown."

RESULTS

Among the 279 physicians responding, 185 (66.3 percent) reported that their routine was to follow in their practices (rather than refer) "DES daughters." Slightly over half of the physicians, 144 out of the 279 respondents (51.6 percent) do colposcopy for abnormal Pap smears. Obstetrician/gynecologists who practiced colposcopy were significantly more likely to manage "DES daughters" than to refer them ($X^2 = 59.3$, 1d.f., significant at the .01 level, Table 1). Among the 135 physicians who responded that they do not do colposcopy in their practices, 104 (77.0 percent) stated that they referred patients to another physician for colposcopic examination when their Pap smear results showed "moderate dysplasia" a month after treatment for vaginitis/cervicitis, and when no lesion was visible on gro examination; the remainder of this group, 35 physician (33.0 percent) responded that they would follow the patie using other techniques (most frequently conization biopsy)

As is shown on Table 2, the physicians practicing co poscopy were trained in this technique recently (83.0 percer within the last eight years). In retrospect, it would have bee interesting to compare the year in which they received the training with the years in which they became board eligib obstetrician/gynecologists. In 1970, Herbst and Scully pub lished a report documenting the highly unusual observatio of clear cell adenocarcinoma occurring in females aged 14 t 22 years.[4] The report of an epidemiologic study whic associated the risk of development of this carcinoma t intrauterine exposure to DES followed.[5] As a consequence c these publications, the search for DES-exposed daughte and their examinations for possible abnormal condition more than likely were responsible for increased interest an utilization of colposcopy in the 1970s.

While 120 of the 144 physicians practicing colposcop reported participation in a short course (few days) of lecture and slides, only 47 (39.2 percent) of these reported the cours as their main method of learning about colposcopy. The nex most common method of learning about colposcopy was b examining patients under the direct supervision of a traine colposcopist (but not as part of a residency or fellowship); 8 of the 144 (55.6 percent) physicians practicing colposcop had direct supervision, but not as part of their residenc training; and 38 (47.5 percent) of the physicians who learne by direct supervision, considered this their main method o learning. For 28 (75.7 percent) of the 37 physicians, th principle colposcopy training was received as part of thei obstetrical/gynecology residency. Other learning method included intensive self-training, short courses given in note centers, or more lengthy or advanced courses. Several re spondents studied with Dr. Hinselmann in Germany (Tabl 3).

TABLE 1
Management of "DES Daughters" by Obstetricians/Gynecologists

Practice colposcopy?	Follow in practice	Referral	Total
Yes	125	17	142
No	60	75	135
Total	185	92	277*

*Two more obstetrician/gynecologists responded that they perform colposcopy, but did not answer the question on DES patient management.

Chi-squared = 59.3, 1d.f., significant .01 level.

TABLE 2
The Year in which the Physician Learned Colposcopy

Year	Number	Percent
1980 to 1981	14	10.4
1978 to 1979	39	28.9
1976 to 1977	29	21.5
1974 to 1975	30	22.2
1972 to 1973	12	8.9
1971 and before	11	8.1
Total	135	100.0

TABLE 3

Learning about Colposcopy

Main way of learning about colposcopy	Follow in own practice		Refer		
	N	%	N	%	Participants*
Ob/gyn residency	24	16.8	4	2.8	37
Gynecological/oncology fellowship	3	2.1	0	0	6
Short course (few days) of lectures and slides	47	32.9	6	4.2	120
Colposcopically examine patients with direct supervision by a trained colposcopist (but not as part of a residency or fellowship)	32	22.4	6	4.2	80
Colposcopically examining patients without supervision	8	5.6	2	1.4	62
Other method	11	7.6	0	0	20
Total	125	87.4	18	12.6	325

*This represents number of physicians who participated in each training method.

TABLE 4

Average Number of Colposcopic Examinations Performed Each Month

Approximate number of procedures/month	Number	Percent
0 to 1	14	9.7
2 to 4	40	27.8
5 to 8	47	32.6
9 to 14	24	16.7
15 to 20	10	6.9
21 to 30	5	3.5
31 to 45	3	2.1
Over 45	1	0.7
Total physicians reporting practicing colposcopy	144	100.0

TABLE 5

Frequency of Following Colposcopy with Cone Biopsy in Management of Severe Dysplasia

Percentage of colposcopic examinations for Pap smears suggestive of severe dysplasia which are followed up with a cone biopsy?	Number	Percent
None	4	2.7
1 to 9	15	10.4
10 to 19	23	16.0
20 to 29	25	17.4
30 to 39	7	4.9
40 to 49	1	0.7
50 to 59	14	9.7
60 to 69	1	0.7
70 to 79	5	3.5
80 to 89	4	2.7
90 to 99	11	7.6
100	25	17.4
Unknown	9	6.3
Total physicians reporting practicing colposcopy	144	100.0

The average number of colposcopy procedures performed per month was in the range of 5 to 8. Only four physicians reported performing more than 30 procedures per month (Table 4). Those practicing colposcopy were asked to estimate the percent distribution of colposcopic examinations performed for various conditions: (1) severe dysplasia, carcinoma in situ, or invasive carcinoma: 19.7 percent; (2) moderate dysplasia: 27.7 percent; (3) mild dysplasia: 28.0 percent; (4) atypia without neoplasia: 14.5 percent; (5) abnormalities other than Pap smears: 5.4 percent; and (6) screening of apparently normal patients: 4.7 percent.

When asked, "Approximately what percentage of your colposcopic examinations for abnormal Pap smears are on patients referred to you because of their abnormal smears?", 32 (23.0 percent) of the 139 physicians who responded to this question said "none" and the remaining 107 physicians reported receiving referrals for an average of 25.5% of their colposcopy caseload.

The frequency of colposcopy followed by cone biopsy in treatment of severe dysplasia (Table 5), on the average, is 45 percent. The distribution was U-shaped with 67 (46.5 percent) of the respondents indicating that under 30 percent of the cases required cone biopsy and 25 physicians (17.4 percent) responding that they always followed up with cone biopsy.

Fees for colposcopy ranged from no charge (according to two respondents) to $175; the average fee was $65.

DISCUSSION

It is plausible that the group of physicians who chose to complete and return the questionnaire were among a subset of the physician population most interested in new techniques and specifically in colposcopy.

As we might expect, 125 (45.1 percent) of the respondents practice colposcopy and follow "DES daughters" in their practices and 75 (27.1 percent) of the respondents did not practice colposcopy and referred "DES daughters." It was interesting to note that 17 (6.1 percent) of the respondents actually practiced colposcopy and yet chose to refer "DES daughters." Sixty (21.7 percent) of the respondents do not practice colposcopy and yet follow "DES daughters" in their

practices. According to Herbst, colposcopy is not always necessary to assess appropriately and follow a "DES daughter."[6]

Considering the response to the question on the utilization of colposcopy for following "moderate dysplasia," it was significant that 77 percent of the physicians who do not practice colposcopy referred their patients for colposcopy. This suggests that these physicians think colposcopy is of value and might well be candidates for learning the techniques so that they might practice it themselves and not need to refer patients. If we believe that patients with "moderate dysplasia" should be followed by colposcopy, we should make every effort to encourage all physicians to practice in this way. However, if the physician is convinced or has determined that a conization biopsy must or should be done, then the colposcopy would be simply an additional procedure without diagnostic value.

We assume physicians who used colposcopy frequently and/or who were experts in colposcopy would be more likely to follow patients with moderate or severe dysplasia and less likely to perform conization biopsies a month after treatment. The survey responses received from three of the five "expert colposcopists" were collated. The percentage of the "expert colposcopists' " examinations that were for Pap smears suggestive of dysplasia ranged from 49 to 97 percent. Among the colposcopic examinations for Pap smears suggestive of severe dysplasia, the percentage on which the "expert colposcopists" performed a subsequent cone biopsy ranged from 25 to 90 percent. Since the question on the survey ("Approximately what percentage of your colposcopic examinations for Pap smears suggestive of severe dysplasia do you follow with a cone biopsy?") did not clearly distinguish between cone biopsies done for diagnosis and those done for treatment, we, therefore, are reluctant to judge the confidence in colposcopy based on the response to this question.

Our survey does not permit us to make a judgment as to what method of instruction in colposcopy gives the trainee the greatest expertise or leads one to feel comfortable in its practice. The survey results show that short courses (three days of lectures and slides) and those combined with dire supervision by a trained colposcopist are the most freque forms of training.

We recognize that colposcopy now is incorporated integrated into ob/gyn residency programs and, therefor we can expect that the most recently certified specialists wi have little need for training courses. It would appear that th most popular and expeditious training method for le recently trained specialists to advocate would be one of sho duration (three days) combined with direct supervision.

The results of this survey were surprising to us in that th practice of colposcopy was more widespread than expecte among the respondents. It was also valuable to us to lear that there might be a greater need for advanced courses tha for beginner courses.

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SPECIAL ARTICLE

Guidelines for the Administration of Blood and Blood Products

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The following information is provided for area hospitals as recommendations that may be helpful in setting up policy and procedure manuals for hospital transfusion committees, house staff, and nursing departments. The recommendations are provided as examples only, since transfusion practices vary from hospital to hospital.

REQUEST FOR BLOOD AND BLOOD PRODUCTS

Recommendations: Erythrocytes

Preoperative requests for blood should be transmitted so that there is adequate time to set up blood in the normal working day.

For acute bleeding, requests will be processed as received.

For chronic anemia, blood should be requested during regular daytime hours unless an anemia-associated emergency exists. Diagnostic samples of serum and bone marrow to determine the etiology of the anemia should be obtained before transfusion. Transfusion will alter the results of these tests.

Requests for typing should state: whether the patient is to be typed and screened only; crossmatched, and for how many units; the type of product; the time at which blood will be required: routine (when ready, hold for call, for surgery, with date), stat, or emergency release.

Certain medications may interfere with crossmatching. If a potential blood recipient is receiving these medications, the laboratory should be informed at the time the order is placed (Table 1).

Specimens for type and crossmatch should be drawn into labeled tubes, with the patient's name and identifying number clearly visible. The person drawing the specimen should be indicated on either the test tube or the transfusion request form. Unlabeled specimens should be discarded by the blood bank.

Significance

Errors in blood banking can be fatal and usually result from misidentification of the specimen or the patient (clerical) and are not technical in origin. It is essential to follow routine procedures and to avoid haste whenever possible.

Recommendations: Platelets

Requests for platelets should anticipate requirements. In general, platelets can be obtained promptly if an emergency exists. Otherwise, 24 hours usually are required.

Random donor platelets are the product of choice except in patients with known sensitization.

Arrangements can be made for donation of HLA type-specific platelets by pheresis, through blood banks. Type specific platelets should be given to Rh negative premenopausal females because of possible sensitization by contaminating red cells, which subsequently could lead to

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TABLE 1
*Medications**

Alpha-methyldopa (Aldomet®)
Mefenamic acid (Ponstel®, Ponstan®)
Levodopa (L-Dopa®, Biodopa®, Dopar®, Larodopa®)
Penicillins (Penicillin G®, Ampicillin®, Methicillin®)
Cephalosporins (Cephalothin®, Keflin®, Cephaloridine®, Loridine®, Cephalexin®, Keflex®, Cefazolin®)
Stibophen (Fuadin®)
Quinidine (Quinaglute®, Quinora®, Cardioquin®, Quinidex®)
Paraaminosalicylic acid (PAS-C®, Pascorbic®, Rezipas®)
Quinine (Quinamm®)
Phenacetin (Buff-A Comp®, Codempiral®, Empirin®, Darvon®, Comp®, Emprazil®, Fiorinal®, Phenaphen®, Soma Compound®, Synalgos®)
Chlorinated hydrocarbon-containing insecticides (Toxaphene®, Heptachlor®, Dieldrin®)
Antihistamine (Antistine®, Antazoline®)
Sulfonamides
Isonicotinic acid hydrazide (Izoniazid®, INH®)
Chlorpromazine (Thorazine®, Clor-PZ®)
Aminopyrine (Pyramidon®)
Dipyrone (Narone®, Pyrilgin®)
L-Phenylalanine mustard (Melphalan®, Alkeran®)
Sulfonylurea (Chlorpropamide®, Diabinese®, Tolbutamide®, Orinase®)
Insulin
Rifampin (Rifadin®, Rimactane®)
Hydrochlorothiazide (Hydrodiuril®)
Acetaminophen
Probenecid (Benemid®)
Carbromal (Carbrital®)
Methadone (Dolophine®)
Tetracycline (Achromycin®)
Streptomycin
Ibuprofen (Motrin®)
Hydralazine (Apresoline®, Hydralazide®, Unipres®)

*From the *Technical Manual, Eighth Edition,* American Association of Blood Banks, 1981.

hemolytic disease of the newborn. If it is not possible to give type specific platelets to Rh negative mothers, Rh immune globulin prophylaxis should be considered.

Current practice specifies use of platelets that are stored at room temperature because of better posttransfusion survival than 4°C stored platelets. Room temperature platelets contain high ammonia levels and should not be used for patients with severe liver disease, for whom fresh or refrigerated platelets may be obtained.

Hemorrhage from thrombocytopenia is uncommon when the platelet counts are more than 30,000/mm³. A rough rule of thumb is that one unit of platelets contains enough to raise the count by 5,000/mm³. This level may not be achieved because of concurrent bleeding, clotting, immune destruction, or splenic sequestration. Platelet transfusion can cause HLA sensitization and should be avoided when possible.

Recommendations: Leukocytes

Requests for leukocytes should anticipate need when possible to assist in planning a transfusion program.

Leukocytes also should be crossmatched, due to the high content of red cells present.

Leukocytes usually are not given unless the patient has fewer than 500 granulocytes/mm³ and has an infection that has failed to respond to antibiotic therapy. The patient's response is the best estimate of the efficacy of transfusion. Once begun, therapy usually is continued for three to seven days.

SIGN OUT OF BLOOD FOR TRANSFUSION

Recommendations

Blood should be signed out from the blood bank only by responsible personnel who understand the hazards of failing to follow accepted procedure. (In many hospitals, this may be done only by registered nurses.) Only one unit of blood should be obtained for one person at one time. (Some hospitals may make exceptions for the operating room when active bleeding is occurring.) In any case, blood for more than one person may never be removed at one time.

To sign out blood, the person receiving the blood and the laboratory technologist together must review data on the unit, including: number of the unit, patient name, patient identification number, type and group of unit and patient, condition of unit, expiration date of unit, and type of component.

Both laboratory technologist and person signing out the blood must sign the log book together. Both review the tag attached to the unit. The time of sign out must be recorded. The unit may then be removed from the blood bank.

Significance

The most frequent cause of fatal or severe hemolytic transfusion reaction is failure to correctly identify unit and recipient. It is essential that the correct unit be given to the patient. Consequently, elaborate procedures are used to guard against error.

BLOOD UNIT TAGS

Recommendations

Each unit of blood must have attached to it a tag showing the following data: patient name, patient identification number, patient blood type and group, blood unit type and group, blood unit identification number, statement of compatibility test, and type of unit.

The tag includes space for sign out of the unit, and the record of patient vital signs before and after transfusion. The front copy of a two-part form can be used as the transfusion record on the patient's chart. Many other types of forms also are satisfactory.

TRANSPORT, STORAGE, AND RETURN OF UNUSED BLOOD

Recommendations

Blood products removed from the hospital blood bank should be taken at once to the location where they will be used and transfused immediately.

Storage of blood products on nursing stations is not recommended practice, whether at room temperature or refrigerated. (Refrigerators on floors are not monitored and frequently are not within the accepted temperature limits.) Blood should be stored only in refrigerators designated and supervised for this purpose by the blood bank director.

Blood not used must be returned to the blood bank within 30 minutes to be accepted for return. Failure to return blood within this time results in discard of the unit and should be the subject of an incident report.

Significance

Blood storage at temperatures below 0°C or above 6°C, may cause hemolysis; storage above 6°C may encourage bacterial growth and shorter red cell survival rendering the blood unfit for transfusion.

Storage of units on nursing stations also may lead to confusion, resulting in transfusion of the wrong unit to a patient.

MASSIVE TRANSFUSION

Recommendations

"Massive transfusion" may be defined as a transfusion of six to ten or more units at one time, or approaching replacement of total blood volume.

Blood for massive transfusions should be obtained from the blood bank, following the usual sign out procedure. Storage of blood at the site of transfusion is not permitted. Taking more than one unit at a time is discouraged unless essential. One person must never sign out blood for two patients at one time.

When it is recognized that transfusion will approach massive proportions, coagulation studies should be obtained, including platelet count, prothrombin time, partial thromboplastin time, and fibrinogen. The initial set of studies will serve as a baseline for subsequent monitoring and later component therapy, if needed.

When massive transfusion is anticipated, use of a microaggregate filter is recommended by certain authorities.

Significance

The patient receiving massive transfusion is exposed to several hazards, including dilution of clotting factors and interference with respiratory function. (When patients bleed massively, there is a tendency for staff to become excited, and errors in procedure may occur if routines are not followed closely.)

ADMINISTRATION OF BLOOD PRODUCTS

Recommendations: Erythrocytes

Blood removed from the blood bank is to be given immediately. It should not be stored at the nursing station. The usual rate for a patient not in congestive failure is completion of the transfusion in one-and-a-half to two hours.

Blood is administered through an appropriate blood administration set. The IV should be in place and functioning before the unit is removed from the blood bank. The blood administration set should be cleared of air before entry into the vein. A 19-gauge or larger needle is recommended for adults. A 21- to 23-gauge needle may be used for small children.

The IV may be held open with normal saline (sodium chloride injection USP). Other solutions may be used provided adequate evidence of safety is available.

No medication may be added to the blood of the IV line used for blood.

The patient's blood pressure, pulse, and temperature must be obtained immediately before transfusion, and recorded on the transfusion record.

Identification of patient and blood product must be done at bedside by two persons, who check that: ABO Group and Rh type of donor and recipient are identical or appropriate; donor number on unit and blood tag are identical; patient number on tag and on wristband match; and patient name on tag and wristband are identical.

The persons identifying the patient and blood product must sign the transfusion record.

Transfusion should begin at a rate of 100 ml per hour for the first 15 minutes, and the patient observed carefully for reaction during the first 5 minutes, and again at 15 minutes when the rate may be increased so that transfusion is completed within two hours. Under no circumstances should the unit of blood be kept or hung at room temperature for more than 4 hours.

Patients with congestive heart failure may have the unit divided in half. Each half is signed out of the blood bank separately and administered over two hours. If the system has been entered into, the shelf life of such divided units is 24 hours.

If a transfusion reaction of any sort occurs, the transfusion must be stopped, and the appropriate procedures followed.

At the end of the transfusion, the transfusion record is completed including posttransfusion vital signs. The blood bag and its tag are returned to the laboratory in a plastic bag. The transfusion record is placed on the chart.

Recommendations: Platelets

The procedures for signing out blood and identification of the patient are the same as for whole blood and red blood cells.

A filter should be used (some microaggregate filters remove platelets).

Platelets need not be group or type specific. Some patients may require HLA-type specific platelets obtained by plateletpheresis. These are ordered by the physician.

Platelets should be infused as rapidly as possible. The units preferably shall be given singly but may be pooled prior to leaving the blood bank. All units removed from the blood bank at one time should be given within half an hour. Usually, the IV is left wide open while platelets are infused.

Recommendations: Leukocytes

Leukocytes are administered in the same manner as red blood cells and whole blood. Single donor or random donor leukocytes may be used.

Multiple units (20 to 25) are given one at a time, the total dose to be given in one or two hours.

Mild febrile reactions are common. Pulmonary symptoms also may occur in the event of a leukoagglutinin reaction.

Each patient should be monitored every 15 minutes during transfusion and every 30 minutes for two hours after transfusion for evidence of fever or respiratory symptoms.

If a febrile reaction occurs, stop the transfusion. Treat the fever as ordered by the physician (e.g. with acetaminophen or hydrocortisone).

Restart the next unit when fever has subsided (transfusion may be continued with mild fever at the discretion of the physician).

If symptoms recur or pulmonary symptoms develop, stop the transfusion entirely.

Patients with a history of previous febrile reactions to leukocyte transfusions may require medication with antipyretics or steroids.

Significance

Transfusion can be a hazardous procedure because of the danger of reaction to incorrectly identified or improperly stored blood products.

WARMING BLOOD

Recommendations

There are few indications for pretransfusion warming of blood. The acceptable indications include: (1) Recipients with cold agglutinin disease. However, some patients with this problem can be transfused safely with a slow rate of transfusion. (2) Rapid transfusion of many units of cold blood may induce ventricular arrhythmias for example in

TABLE 2
*Alternate Donor Group**

Patient Group	1st Choice	2nd Choice
A	O	—
B	O	—
AB	A	O
O	—	—

*From the *Technical Manual, Eighth Edition,* American Association of Blood Banks, 1981.

trauma, surgical bleeding, or exchange transfusion.

When blood is warmed, it must be maintained at 37°C. Blood can be warmed by use of a commercial blood warmer with close quality control of temperatures and so documented.

Significance

In most instances, the risk of hemolysis that can occur from warming blood is greater than the morbidity caused by transfusion of cold blood. Therefore, blood warming is discouraged except for indications specified.

The danger of hemolysis is especially great if blood is warmed above 40°C.

Good practice requires that only the portion of blood ready to enter the vascular system be warmed.

MICROAGGREGATE FILTERS

Recommendations

Microaggregate filters may be used for massive transfusion or when such transfusion is anticipated.

Certain microaggregate filters also are recommended for removing granulocytes and other debris from red blood cells to reduce the incidence of nonhemolytic febrile reactions. Some microaggregate filters can trap platelets.

Microaggregate filters must not be used for granulocyte transfusion.

Significance

Fibrin particles, clumps of white blood cells, disintegrating platelets, or even small blood clots, can be formed in bank blood even after a few hours of storage. The aggregates are filtered in the microcirculation of the lung. After infusion of large amounts of blood, pulmonary insufficiency may develop from the microaggregates. Some authorities question the need for and efficacy of microaggregate filters.

USE OF NONGROUP AND TYPE SPECIFIC BLOOD

Recommendations

The use of nonspecific blood is discouraged. The patient's physician and the blood bank director should be notified before such blood is given.

If every effort has been made to obtain blood of the patient's own type, compatible blood may be given as shown in Table 2.

When alternate type blood is used, packed cells are to be given.

After using alternate group blood, compatibility in the patient must be proved by repeat crossmatching with a fresh specimen before reverting to the patient's own type.

In an emergency, Rh+ blood may be given to an Rh− individual who has not been sensitized previously. This should be avoided in women of childbearing age. However, if Rh+ blood is given to these Rh− women, the use of Rh-immune globulin should be considered.

TABLE 3
*Types of Immediate Reaction**

Acute hemolytic	.06/1000
Anaphylactic	rare
Circulatory overload	uncommon
Pulmonary edema	rare
Febrile nonhemolytic	3/1000
Allergic	1.6/1000
Bacterial contamination	rare
Types of Delayed Reaction	
Delayed hemolytic reaction	0.7/1000
Infection—hepatitis, malaria, cytomegalo virus	

*From Schmidt PJ: Transfusion reactions in 1982. *Clinics Laboratory Med* 2: 221-231, 1982.

Rh− blood may be given to an Rh+ individual.

Significance

Alternate group blood must be selected carefully to prevent a hemolytic transfusion reaction, and should be avoided when possible.

At times, shortages of certain blood types may force use of alternate group blood.

Anticipation of blood needs will help in minimizing use of alternate group blood.

AUTOLOGOUS TRANSFUSION

Recommendations

In certain instances, especially elective surgery, it is preferable to obtain blood from the patient for transfusion at surgery.

To obtain adequate amounts of blood, the patient must begin donation several weeks prior to surgery. If more than four units of blood are required, a schedule can be developed through the blood bank for drawing two units and replacing one each week.

The patient must take oral iron and vitamins during the donation period.

At least 72 hours must elapse between the last donation and surgery.

Blood not used for autologous transfusion may be released 72 hours after surgery to general inventory, if the donor satisfies the criteria for blood donation, and signs a release for the blood.

Significance

The safest transfusion for any patient is his or her own blood, since it carries no risk of hemolytic, allergic, or febrile reaction and will not transmit disease such as hepatitis.

In certain patients, those with rare blood types, or history of transfusion reaction, or those with known antibodies, autologous transfusion may be essential. Blood from these patients also can be frozen for future use by reference blood banks.

RETURN OF BLOOD BAGS TO THE BLOOD BANK

Recommendations

Following completion of transfusion of blood products, the blood bag is disconnected. The transfusion record and blood bag tag are completed, including the patient's vital signs.

The bag and tag should be returned promptly to the blood bank. The bag is placed in a plastic sandwich bag which is

TABLE 4
Transfusion Reaction Report

Patient's name _____

Medical record no. _____ **Room** _____

Identification no. _____ **Age** ____ **Sex** ____ **Physician** _____

In the event of actual or suspect transfusion reaction:

1) Stop the transfusion
2) Check name and identification no. of patient and unit
3) Notify: (a) physician (b) laboratory
4) Check ABO and Rh of unit and patient
5) Immediately return unit and transfusion set to lab
6) Complete top portion of this form
7) Obtain first urine specimen, send to lab marked: transfusion reaction specimen

Reason for transfusion _____

Pretransfusion hemoglobin ____ gm/dl ( ) Chronic anemia (etiology _____)

( ) Active bleeding (site ____) ( ) Trauma ( ) Surgical ( ) Shock

Blood administered at: ( ) ER ( ) OR ( ) RR ( ) Floor ( )
( ) Preop ( ) Postop

Recheck of patient ID with blood unit tag: ( ) OK ( ) Discrepancy _____

Blood Unit No. ABO Rh ( )RBC ( ) WB ( ) Other _____

Time started _____ Amount given _____ Time of reaction _____ Time stopped _____

Vital signs: Pretransfusion	Posttransfusion
_____ BP	_____ BP
_____ Pulse	_____ Pulse
_____ Temp	_____ Temp

Symptoms of reaction: Narrative _____

During	After	Transfusion	During	After	Transfusion
( )	( )	Hives or rash	( )	( )	Headache
( )	( )	Chilly sensation	( )	( )	Dyspnea
( )	( )	Shaking chills	( )	( )	Nausea
( )	( )	Generalized pain, tingling	( )	( )	Tachycardia
( )	( )	Anxiety	( )	( )	Fever
( )	( )	Chest pain or fullness	( )	( )	Hypotension
( )	( )	Back pain	( )	( )	Abnormal bleeding
( )	( )	Dark urine	( )	( )	Other

Reported by _____ R.N. Date _____ Time _____

secured at the top with a tie. The tag remains attached to the bag, but should be pulled outside the bag so that it will not be damaged by leakage from the blood bag itself.

Significance

Donor blood carries a risk of infectious hepatitis to which hospital personnel should not be exposed by contact with a messy blood bag.

The blood bag (or its segments) is kept in the laboratory for 10 days so that it can be examined in the event that delayed complications of transfusion should occur.

TRANSFUSION REACTIONS

Recommendations

All patients receiving transfusions must be observed carefully for transfusion reactions during the period of transfusion and after.

Transfusion reactions may be immediate or delayed (Table 3).

Acute hemolytic transfusion reactions potentially are lethal. The goal of investigation of all reactions is to determine

TABLE 5

Transfusion Reaction Report

Blood bank studies

1. Clerical review

Pretransfusion:	ABO	Rh	Du	Ident. no.	Antibody screen	Initial crossmatch
Donor unit 1						
2						
3						

2. Evidence of hemolytic reaction: Posttransfusion direct AHG test _____
   Posttransfusion hemoglobin in: Serum___ Date and time drawn _____
   Urine___ Date and time obtained _____

3. Confirmation of group and type:

Recipient	ABO	Rh	Du
Pretransfusion			
Posttransfusion			

4. Conclusion: Evidence of error ( ) Yes ( ) No Hemolysis ( ) Yes ( ) No
   (If both answers are no, and reaction is hives, rash, fever, or sensation of chills, workup may stop at this point. If yes, continue and complete steps 5 to 9).

5. Repeat testing: Antibody screen (patient)_____

Crossmatch		RT	Saline	Albumin	37° Antiglobin
Pretransfusion	1				
	2				
	3				
Posttransfusion on segment and cells from blood bags	1				
	2				
	3				

   Conclusion: ( ) All units compatible ( ) No irregular antibodies
   ( ) Other _____

6. Bacteriology: Gram stain _____ Culture begun ( ) Yes ( ) No

7. Additional tests: Posttransfusion Hemoglobin ___ mg/dl Time _____
   Serum bilirubin pretransfusion ___ mg/dl Date _____
   posttransfusion ___ mg/dl Date _____ Time _____
   Serum creatinine posttransfusion ___ mg/dl Time _____

8. History:
   Transfusions ( ) This admission No. _____
   ( ) Previous No. _____
   ( ) Allergy _____ ( ) Pregnancy _____
   ( ) Previous reactions: Type _____ Dates _____

9. Comments: _____
   Testing completed by _____ Date and Time _____
   Pathologist's conclusions
   Type of reaction: ( ) Allergic ( ) Febrile ( ) Overload ( ) Hemolytic
   ( ) Cause undetermined ( ) Other
   Recommendations: _____

_____ M.D.
Pathologist

whether a hemolytic reaction could have occurred. The most common cause is identification error.

Symptoms and signs suggesting hemolytic transfusion reaction include: low back pain, pain at infusion site, fever, shaking chills, chest pain, hypotension or shock, generalized bleeding, hemoglobinuria and oliguria, dyspnea, flushing, anxiety, nausea or vomiting, and rash or hives.

Many of these symptoms are nonspecific and are similar to those occurring in nonhemolytic reactions:

- if any type of reaction is suspected, the transfusion must be stopped at once. Leave the IV running with saline.
- Check the identity of patient and blood bag, together with all numbers and blood group and type.
- Notify the attending physician and blood bank.
- Check the patient's blood pressure, pulse, respirations, and temperature. Record these on the transfusion reaction study sheet.
- Document the symptoms of reaction (chills, fever, shock) on the reaction study sheet (Tables 4 and 5) and complete the sheet.

- Obtain blood samples (serum tube and EDTA tube). Transmit these to the laboratory with the first voided urine specimen, the blood bag, and the transfusion reaction sheet.
- In the laboratory, the workup for transfusion reaction consists of rechecking all clerical work, checking for free hemoglobin in urine and serum or plasma, a direct antiglobulin test, and reconfirmation of pre- and post-transfusion recipient blood group and type. If an error has been made, or if there is evidence of hemolysis or of positive direct antiglobulin test, further workup may include recross match (pre- and posttransfusion), with samples from the blood bag and its segments, culture of the blood bag, serum bilirubin, haptoglobin, creatinine, and posttransfusion hemoglobin.

Anaphylactic reaction usually occurs at the beginning of the transfusion. Symptoms and signs suggesting anaphlyaxis include: shock, hypotension, flushing, wheezing, dyspnea, nausea, cyanosis, and pain in back, chest, and abdomen.

Transfusion must be stopped at once and procedure for acute hemolytic reaction followed. Such a reaction may occur in IgA deficient patients and this should be excluded.

Circulatory overload usually is caused by excessive transfusion leading to congestive heart failure. The condition has the same symptoms as congestive heart failure and is treated the same way. The transfusion should be stopped if symptoms of congestion are noted, and the attending physician notified. (Overload can be avoided by giving the transfusion in divided units, over a longer period of time, or by partial exchange transfusion.)

Noncardiogenic pulmonary edema may result from trapping of microaggregates of transfused cell or cell debris in the pulmonary circulation. Symptoms often occur after infusion of a small volume, insufficient to produce circulatory overload. The respiratory distress may be accompanied by chills, fever, cyanosis, and hypotension. If symptoms of pulmonary edema are recognized, the transfusion should be stopped and the attending physician notified immediately.

Febrile nonhemolytic reactions are defined as an elevated temperature of 1°F (0.5°C) or more. They often are caused by leukocyte agglutinins. The following should be instituted:

- The transfusion should be stopped immediately and the IV kept open with saline.
- The physician and the blood bank should be notified immediately.
- The reaction study sheet is completed.
- The laboratory obtains postreaction blood and urine specimens.
- The patient now may be treated with antipyretics if necessary.
- If no evidence of hemolytic reaction is identified on preliminary workup, the patient may have further transfusion as ordered with antipyretics as ordered.
- If the patient has repeated febrile reactions, leukocyte-poor blood or washed red blood cells may be used.

Allergic reactions often may be caused by an allergenic substance in the donor plasma.

Symptoms and signs of an allergic reaction may include: hives or urticaria, rash, and itching.

The physician and blood bank are notified. The transfusion is stopped.

Some laboratories request blood and urine specimens be obtained as for a hemolytic reaction.

If the patient responds to treatment with antihistamines, no further symptoms occur, and no further evidence of a hemolytic reaction is found, no additional work is required.

Delayed hemolytic reaction may occur as a response to a transfused antigen to which the patient had an antibody undetectable by usual laboratory methods. The transfusion caused a secondary or "anamnestic" increase in antibody, which then attacks the transfused cells. The reaction may occur in one to five days after transfusion. Rarely, a weak primary immunization reaction may occur two weeks or more after transfusion.

Symptoms of a delayed transfusion reaction may be those of an acute hemolytic reaction or they may be of gradual onset, with hemoglobinuria, jaundice, or decreasing hemoglobin levels in the absence of bleeding.

If a delayed reaction is suspected, the physician and blood bank should be notified, appropriate testing done, and the patient's urine output and renal function followed.

Delayed reactions are only rarely severe enough to cause renal damage.

Significance

Transfusion reactions can be fatal. They must be detected early and evaluated promptly. Suspected reactions are much more frequent than true reactions, but each must be evaluated thoroughly.

CONCLUSION

The opinions expressed are those of the authors. Several reference materials were consulted in the preparation of these guidelines.[1-5]

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Graves' Disease Following Resection of an Autonomous Solitary Thyroid Adenoma

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We report an unusual case of Graves' disease in a 56-year-old female, 15 months following resection of an autonomously functioning thyroid adenoma. The diagnosis of Graves' disease was supported by thyroid scan and CT scan of the extraocular muscles. While the concurrence of two thyroid diseases with different etiologies may have been coincidental, we discuss the possibility of stress-induced Graves' disease, in the light of current immunologic theory and the possible role of TSI in the evolution of autonomous adenomas.

Autonomous adenomas of the thyroid gland with or without the clinical picture of hyperthyroidism are thought to be true follicular adenomas of unknown pathogenesis.[1] The adenoma is capable of functioning without stimulation by TSH or other thyroid-stimulating immunoglobulins.[2] On the other hand, Graves' disease is thought to have an autoimmune etiology[3] and frequently is characterized by one or more circulating immunoglobulins at some stage during the disease process. The peripheral manifestations of toxic adenoma generally are milder than Graves' disease and the former is not associated with pretibial myxedema or thyroid ophthalmopathy. A review of the literature reveals only a single case where these two diseases occur in a close temporal relationship in the same patient.[4] For this reason, we report a case of Graves' disease diagnosed in a woman 15 months following resection of a proved autonomously functioning thyroid adenoma.

CASE REPORT

A 57-year-old black female was referred to the University Hospital for evaluation of a neck mass. She stated that there was progressive growth of this neck mass with associated dysphagia for 2 to 3 years. She denied previous thyroid disease, tachypnea, weight loss, or diarrhea. The past medical and surgical histories were negative.

The patient was alert and anxious, but not hyperkinetic or diaphoretic. Pulse rate was 80/min, regular; blood pressure, 120/80; temperature, 98.0°F. A 4 cm firm, slightly tender nodule was palpated at the left lower thyroid pole. The remaining thyroid tissue was not palpable. There was no evidence of proptosis, lid lag, or other ocular findings. There were no carotid or thyroid bruits; the heart was normal in size with no precordial heave or murmurs. The lungs were normal to auscultation and there was no lymphadenopathy or splenomegaly. The neurologic examination was normal; reflexes were not hyperactive.

LABORATORY

Complete blood count, serum electrolytes, and tests of renal function were normal. Serum calcium, 9.9 mg/dl; albumin, 3.7 gm/dl; serum cholesterol, 255 mg/dl. Chest x-ray revealed slight cardiomegaly with tracheal shift to the right. T_4 RIA, 9.6 μg/dl (normal 5 to 12 μg/dl); FT_4, 2.2 ng/dl (normal: 1.0 to 2.4 ng/dl); T_3 RIA, 1.0 ng/ml (normal 0.6 to 2.4 ng/ml); TSH, undetectable (normal <10 miU/ml).

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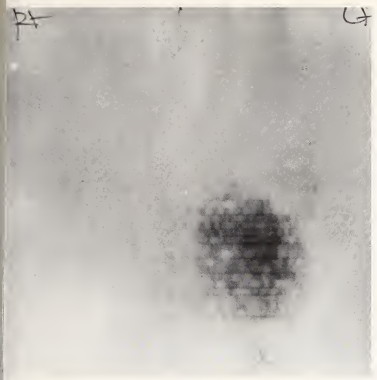


Figure 1—Tc99 scan demonstrating a solitary "hot" thyroid nodule with suppression of the remaining thyroid tissue; x represents suprasternal notch.

A thyroid scan performed with three mCi of Tc^{99} and an uptake with 2.7 uCi of I^{131} revealed a solitary "hot" nodule involving the lower two-thirds of the left lobe with suppression of the remaining thyroid tissue (Figure 1). The 24-hour radioactive iodine uptake was 28 percent (normal: 10 to 30 percent). A suppression test, using triiodothyronine revealed no suppression of the thyroid nodule by scan. A three-day stimulation test (10 units of TSH were administered intramuscularly daily) resulted in a clear delineation of increased uptake in the remaining thyroid tissue.

This confirmed the diagnosis of an autonomous solitary thyroid nodule.

Due to persistent complaints of dysphagia and cosmetic disfigurement, a left thyroid lobectomy was performed.

The surgically resected left lobe of the thyroid gland, weighing 20 gm, contained a well-encapsulated nodule that was 3 cm in diameter. The cut surface of the nodule was pale yellow with small focal hemorrhagic areas. The remaining thyroid tissue was grossly unremarkable.

The histological examination revealed the nodule to be a follicular adenoma. The remaining thyroid tissue showed normal lobular and follicular architecture.

The patient did not return for her followup clinic appointment but returned to the hospital 15 months later with the chief complaints of nervousness, irritability, and weakness. She also noted increased sweating, anxiety, pruritis, hand tremors, palpitation, 30 pounds weight loss, and intermittent diarrhea.

The patient was anxious and hyperkinetic, in no acute distress. Temperature was 98.6°F; pulse rate was 110 per min regular rhythm. The neck revealed a palpable smooth right thyroid gland about twice normal size. There was no bruit. The left lobe was not palpable. A stare, with lid retraction but no proptosis, was noted. A grade III/VI systolic ejection murmur was heard best at the left sternal border. Respiratory and abdominal examinations were normal. Neurological examination revealed a fine tremor of the outstretched fingers of both hands; extraocular muscles were normal, reflexes 3+ to 4+ bilaterally. The skin was silky,



Figure 2—Tc99 scan revealing diffuse homogeneous uptake in an enlarged right lobe and a small amount of uptake in the remnant of the left lobe; x represents cricothyroid cartilage.



Figure 3—GE CT/T 8800 CT scan of the orbits. The dotted line represents the width of the inferior rectus muscle.

smooth, and warm. There was no onycholysis but the hair fell out quite easily.

Complete blood count, urine analysis, and serum electrolytes were normal. Serum urea nitrogen, creatinine, phosphorus, and liver function tests were normal. Serum calcium concentration was 10.2 mg/dl; cholesterol, 180 mg/dl; serum glucose, 121 mg/dl. Thyroid studies: T_4 RIA, 20 μg/dl (4.5 to 11.5 μg/dl), free T_4, 6.2 ng/dl (0.8 to 2.3 ng/dl), T_3 RIA, 8.0 ng/ml (0.8-2.2 ng/ml). Chest x-ray revealed cardiomegaly with tracheal deviation to the left corresponding to an enlarged thyroid lobe. EKG revealed sinus tachycardia with occasional atrial premature contractions and ventricular trigeminy. A 24-hour RAI uptake and scan revealed an increased uptake of 50 percent (normal 10 to 30 percent) while the scan revealed a diffuse homogeneous uptake in an enlarged right lobe, and a small amount of uptake in the remnant of the left lobe (Figure 2). A CT scan of the orbits (Figure 3) revealed enlarged bellies of the inferior rectus muscles—0.85 cm and 0.86 cm (>50 percent enlarged). This finding supports the diagnosis of Graves' disease.[4] Thyrotropin displacing activity was performed and was negative. Propylthiouracil and propranolol were administered and resulted in euthyroid status. All symptoms including arrhythmias abated.

DISCUSSION

The patient presented in this report had clear clinical and histologic evidence for a functioning benign neoplasm of the thyroid gland. These adenomas are of unknown etiology but to our knowledge are not related to autoimmune phenomena. The radioactive iodine scan showing a single "hot" nodule with suppression of the remaining thyroidal tissue, along with stimulation of the suppressed areas by exogenous TSH, confirmed the clinical diagnosis. The diagnosis of Graves' disease in the second admission rather than a second functioning autonomous adenoma was confirmed by the CT scan of the orbits. The CT scan can be helpful in cases in which the etiology is not apparent. As in this patient, the swelling of the extraocular muscles in Graves' disease generally occurs within their bellies with sparing of the tendonous insertions, a feature that helps to distinguish the enlargement of Graves' disease from that of inflammatory myositis.[5] Thyrotropin displacing activity (TDA) was performed and was negative. This assay is negative in approximately 25 percent of patients with Graves' disease and therefore does not rule out the diagnosis in this patient.

Our patient is remarkably similar to a previously described 48-year-old female with a family history of Graves' disease who presented in a euthyroid state with a single "hot nodule" suppressing uptake of the remainder of the gland.[4] Three years later, she developed frank thyrotoxicosis from a hyperfunctioning nodule and was treated with I^{131}. Seven weeks later, the patient became more hyperthyroid; the scan revealed diffuse thyroidomegaly leading to the diagnosis of Graves' disease.

It is possible that the concurrence of an autonomously functioning thyroid nodule and Graves' disease is coincidental. However, many cases of hyperthyroidism following a variety of stresses, including surgical and psychological, have been reported in the literature. Graves' disease has been known to occur following psychological trauma since the original descriptions by Parry in 1825 and Graves in 1835.[6] Morillo and Gardner describe four cases of this phenomenon in children.[6] Additionally, thyrotoxic Graves' disease has been reported to follow irradiation for Hodgkin's disease,[7] cyclophosphamide therapy,[8] and subacute thyroiditis.[9] It may occur during the course of Hashimoto's thyroiditis.[1] While some observers feel that the stressful situations and the later occurrences of hyperthyroidism are coincidental, others feel differently. Volpe feels it is possible that stimulation of the hypothalamic-pituitary-adrenocortical axis with the resultant hypercortisolism would allow a genetic partial defect in suppressor T lymphocytes to become manifest. In support of this concept, Keller demonstrated that graded series of stressors resulted in progressive diminution of lymphocyte function.[10] Additionally, Graves' disease has been initiated in patients taking corticosteroid therapy.[11]

An alternate hypothesis, which is attractive but as speculative, is suggested by the work of Larsen et al.[12] They demonstrated in vitro hyperresponsiveness to TSH in human thyroid adenoma tissue as measured by organification of iodide and adenylate cyclase activity. Since Graves' disease is thought to be caused by an immunoglobulin with thyroid-stimulating properties, it is possible that stimulation of a hyperresponsive zone could result in an autonomous adenoma as an early manifestation of Graves' disease.

CONCLUSION

We have described an interesting sequential occurrence of Graves' disease in a patient 15 months following a thyroid lobectomy for an autonomous adenoma. This sequence emphasizes the possibility that Graves' disease and a functioning adenoma may occur in the same patient despite different proposed pathogenetic mechanisms.

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Incidental Finding of a Mediastinal Lipoma in a Child Following Trauma

RICARDO SEPULVEDA-MALEC, M.D., JOSEPH J. AMATO, M.D.,
M.A. ALI KHAN, M.D., ANITA FALLA, M.D., Newark*

A four-year-old child was found to have a mediastinal lipoma following severe trauma to the chest. Lipomas comprise less than 1 percent of all mediastinal tumors. Management depends primarily upon age, presenting symptoms, and location as determined by chest roentgenograms, sonography, and computerized axial tomography.

Mediastinal lipomas are rare tumors originally described by Fothergill in 1781. Since then, approximately 130 cases have been reported; of these, less than 15 cases were found in children under the age of 12.[3]

CASE REPORT

A four-year-old black female was admitted to Children's Hospital of New Jersey, United Hospitals Medical Center, following a fall from a third-floor roof. The major impact of injury was to the left upper part of the body that hit the cement sidewalk. She had been unconscious for a short period of time. When initially examined in the emergency room, she was alert and oriented. The vital signs were stable as follows: BP 130/80, pulse 120/min and regular, respiratory rate 18/min, temperature 37.6°C. No obvious areas of deformity or bleeding were found.

Positive physical findings included multiple abrasions and contusions in the left shoulder region and lateral chest wall. Initial x-rays of the skull, abdomen, left upper and lower extremities, and intravenous pyelogram were normal. The chest x-rays showed a rounded density in the upper part of the left hemithorax (Figure 1); it did not appear to displace the heart or mediastinum and was posterior in location. No fractured ribs were noted. She was admitted to the Pediatric Intensive Care Unit for treatment, observation, and further diagnostic studies. To rule out the presence of a vascular injury at the thoracic inlet or primary mediastinal tumor, ultrasound studies of the chest were performed. A discrete solid mass was demonstrated. Selective right heart catheterization with left pulmonary bronchial and intercostal arteriography revealed an atypical extrapleural mass with no apparent vascular supply. The upper lobe was noted to be compressed by the mass. The aortic arch and left subclavian artery clearly were intact. Other studies including a computerized axial tomography scan (CT) of the head were normal. Twenty-four-hour urine studies for vanillyl mandelic acid and catecholamines were within normal limits. An intrathoracic neoplasm now was the preoperative diagnosis.

Under general endotracheal anesthesia, a left posterolateral thoracotomy was performed and a well-encapsulated, oval, fatty, yellow mass was found measuring 8 x 6 x 3 cm (Figures 2 and 3). The typical appearance was that of a large, soft lipoma displacing the left upper lobe anteriorly. The lipoma arose from the posterior mediastinum by means of a fatty pedicle and was attached loosely to the upper descending thoracic aorta. The mass was excised completely. Postoperative recovery was totally uneventful and the patient was discharged on the seventh postoperative day.

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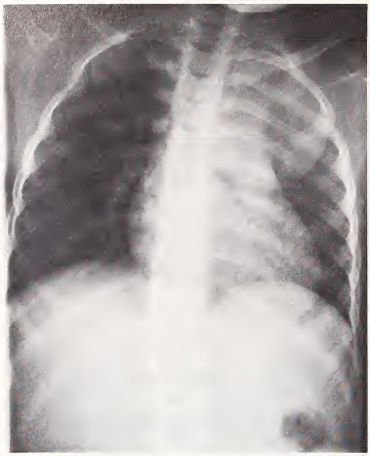


Figure 1—Illustrates the well-rounded mass density occupying the upper part of the left hemithorax, as well as the intact bony thorax structures.

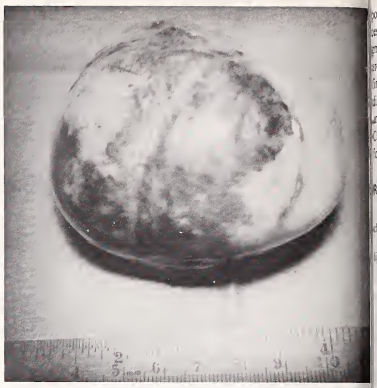


Figure 2—Photograph of the excised intrathoracic lipoma showing the well-encapsulated, oval-shaped tumor measuring 8 x 6 x 3 cm.



Figure 3—Photograph of the excised intrathoracic lipoma showing the typical homogenous fatty tissue.

DISCUSSION

Although lipomas are the most common benign neoplasms, occurrence within the thoracic cage is uncommon. Jensen and Petersen reviewed 3,502 pulmonary tumors. Only 65 tumors were benign (1.9 percent) and, of these, 3 were lipomas.[9] In contrast to the frequent multiple subcutaneous lipomas, the intrathoracic lipoma usually is a single lesion. Multiple intrathoracic lipomas are rare. Lipomas seen within the thoracic cage can be classified as follows:

Mediastinal—The anterior mediastinum appears to be the most common site of intrathoracic lipomas, that are true neoplasms. These lipomas should not be confused with the "mediastinal lipomatosis" seen in patients with Cushing's syndrome. The vast majority are discovered by routine chest roentgenogram.[1,2,4,7] In the late stages, symptoms are related to compressive effects upon important contiguous structures. Compression of a major bronchus or lung parenchyma may cause dyspnea. Dysphagia due to compression of the esophagus also has been reported.[4] Feeling of substernal oppression has been a common complaint in patients with large mediastinal lipomas. Some have had a palpable cervical mass as an extension of the mediastinal lipoma. Exploratory thoracotomy is required for accurate diagnosis.

Endobronchial Lipoma—Despite the widespread use of bronchoscopy, endobronchial lipomas remain a rare entity. Their true incidence is uncertain. Among nearly 3,000 consecutive, surgically resected lung specimens, only 3 endobronchial lipomas were found.[10] Only 50 cases of endobronchial lipoma have been reported in the English literature. They usually are pedunculated, relatively avascular tumors composed of mature fat cells and covered with normal respiratory mucosa. The tumor is attached by a narrow stalk. Occasionally, they tend to produce hemoptysis presumably due to infection distal to obstruction late in their course. At bronchoscopic examination, they appear as smooth, rounded, submucosal tumors, usually pale pink or gray, pedunculated, and freely movable. Endoscopic removal may be attempted and if unsuccessful, a formal thoracotomy should be performed.

Parenchymal Lipomas—These are extremely rare and in a majority of the reported cases, the lesion was recognized only after operative removal had been accomplished.

Pleural Lipomas—These also are very rare. Presumably, they arise from the submesothelial layers of the visceral parietal pleura. They may grow subpleurally into the pleural space or extrapleurally and are found incidentally on a routine chest roentgenogram. The only reliable method of diagnosis and treatment is exploratory thoracotomy and excision of the tumor.

Cardiac Lipomas—While very rare, several cases of successful surgical removal of cardiac lipomas have been re-

ported. The largest cardiac tumor ever reported and successfully removed was an intracardiac lipoma weighing 2,500 gm.[11] In general, the symptoms and signs of cardiac lipomas are nonspecific as are the electrocardiogram and chest x-ray findings. Cardiac catheterization is very beneficial in diagnosis of this intracardiac tumor. Echocardiography is another very useful noninvasive method of diagnosis. Cardiac lipomas usually are resectable and are a curable form of heart disease.

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Detoxification/Acute Treatment

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Once the identified impaired physician has been confronted and assuming that the diagnosis has been accepted, the issue of the need for immediate management of the acute phase of the illness arises. The first consideration here is the nature of the impairment with which we are concerned.

Detoxification from alcohol may be a prerequisite to initiation of an intensive inpatient rehabilitation program. Withdrawal from mood-altering chemicals other than alcohol also may require a period of supervised withdrawal before rehabilitation can proceed.

In the case of the physician whose impairment is due to mental illness, a careful evaluation and decision must be made about the necessity of immediate inpatient treatment to stabilize acute decompensation. When we are confronted with physicians with other impairments such as senility or disabling neurologic disorders, the issue of immediate acute care hospitalization seldom arises. In the event that it should, good medical judgment would be employed in selecting appropriate treatment.

The second consideration involves the availability of appropriate facilities for the particular problem. There are many first-class treatment facilities in New Jersey and in the neighboring states to provide acute detoxification for alcoholism and/or substance abuse. The New Jersey State Department of Health publishes and periodically revises separate directories of treatment and rehabilitation resources in New Jersey for both conditions. Copies are available upon request from the State Department of Health. In the absence of such a directory, information is available through the Impaired Physicians Program at the Medical Society of New Jersey (609-896-1766).

A third consideration in the selection of the acute care facility is its proximity to and established transfer agreement with the proposed inpatient rehabilitation programs that are chosen for the ongoing treatment of an impaired colleague. Often, both facilities are an integral part of the same program providing ease of progression from detoxification to rehabilitation. It sometimes may be necessary to handle each phase as a separate hospitalization.

In rare instances, for personal or economic reasons, the physician is unable to be admitted for detoxification into an inpatient setting. In less seriously decompensated cases it is possible to manage detoxification at home provided that an interested and willing addictionologist will supervise the treatment and that a concerned third party is available to monitor the compliance of the physician with the treatment regime.

In a similar manner, in an acutely agitated emotionally disturbed physician, the availability of a willing and experienced therapist, together with a competent third party may allow for stabilization on an outpatient basis.

A critical part of this period of detoxification or stabilization is the need to submit the physician to a thorough physical examination including all pertinent laboratory studies.

It is well known that few physicians practice what they preach when it comes to their own health maintenance. In addition, the impairments with which we are concerned bring their own set of health problems.

This is the appropriate time to document and address all of the physician's diagnoses, and those that demand immediate attention should be treated properly, if possible, before the rehabilitation program begins. On the other hand, chronic stable disorders that pose no immediate threat can be deferred until after the rehabilitation phase is completed.

In the case of the substance abusers, the workup should provide for consideration of the possible presence of a major psychiatric illness along with the alcoholism or drug dependency. Each component must be diagnosed carefully and treated appropriately or a poor result will be inevitable.

In most cases, however, it is extremely difficult to establish a clear-cut psychiatric diagnosis until the alcohol or drug problem has been well stabilized. Opinion varies among the experts on how much time is required. Most people would accept a 3- to 6-month delay in attempting to establish a firm psychiatric diagnosis.

This does not mean that we should ignore obvious evidence of psychiatric illness simply because of the time frame suggested. There are few areas in medical diagnosis where such skill may be required as in deciding when behavioral disorders are due to substance abuse or underlying mental disease.

The treatment of the acute phase of these disorders stabilizes these patients and prepares them to progress into intensive rehabilitation efforts.

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WHAT IS YOUR OPINION?*

Health Care in South Jersey

JAMES E. BRENNAN, M.D., Collingswood**

In the January, 1983, issue of *The Journal*, Dr. Stanley Bergen characterized the health care in South Jersey as "bleak." In his comments, Dr. Bergen cited the high infant mortality rate in Camden City at 37 infant deaths per 1,000 births, the high rate of cardiovascular disease, cancer, and accidents, and the health manpower shortage areas, but credits the AHEC Program, under the jurisdiction of UMDNJ-NJSOM, as achieving "marked improvements" in "upgrading the health care system of the greater Camden area."*** After reading Dr. Bergen's article, one would assume that southern New Jersey was barren of health planning and medical expertise before 1980. This is not the case. While the implication is that AHEC has been instrumental in bringing "primary care to citizens who never had it before on a consistent, ongoing basis . . . ," it is important to recognize that this is a federally-sponsored program to address any deficits in the type and number of health profession educational programs. Therefore, while its objective may be to improve health care delivery, it is to be accomplished primarily through educational programs.

As President of the Camden County Medical Society, whose physicians (through their respective hospital institutions) have served the residents of the greater Camden region, I wish to point out the serious misrepresentation of the health care picture in this region through Doctor Bergen's characterizations. The statistics mentioned regarding infant mortality reflect the picture in Camden City in 1977. However, by 1980, the infant mortality rate already had dropped to 20.3, just slightly more than 1.5 times the state rate (12.5), and the Camden County rate was just 13.6. By 1981, the infant mortality rate dropped further to 16.3 for the city, 10.5 for the county, with the state average being 10.6. By comparison, the same rate in 1981 for the city of Newark is 17.3, East Orange, 23.7, and Essex County, 14.8.

The Area Health Education Center (AHEC) began in 1980, long after the decline in infant mortality already had begun. Our Lady of Lourdes Medical Center, West Jersey Hospital, and Cooper Hospital, already had been offering and improving the quality of maternity and newborn care to county residents. In 1981, Cooper and Lourdes were designated a joint level III perinatal center. Cooper and Lourdes through their adult, adolescent, and high-risk clinics, provide high-quality obstetrical and perinatal care to an almost exclusive Camden City population. Much work had been done on the part of very dedicated people to influence the perinatal and neonatal outcomes.

Cooper Hospital, initially through its own facility, and subsequently through cooperation with the establishment of the independent CamCare Corporation, is delivering significant health services to Camden residents. CamCare now operates three separate health care centers for primary care in adult medicine, a primary care center for pediatrics, and an emergency outpatient and inpatient mental health primary care center in conjunction with Our Lady of Lourdes. CamCare provides care to over 16,300 Camden City residents, and will have 93,000 service encounters this year. The total budget for the entire program is only $2.6 million. In addition, Cooper Hospital provides specialized outpatient services to Camden residents in cleft palate, general and orthopedic surgery, and child development.

Our Lady of Lourdes through its Osborne Family Health Clinic has served 19,700 registered clients, or some 10,000 families and experiences 20,000 clinic visits annually. The services offered at the Osborne Clinic specifically are directed towards primary care, utilizing the total family care concept, and includes adult medicine, pediatrics, and ob/gyn, as well as a high-risk neonatal followup clinic and a clinic for adolescent parents. Of the patients served, 70 percent are from Camden City, and 65 percent are minorities. Lourdes also provides specialized outpatient services in rehabilitation, ophthalmology, child development, pediatric neurology, cardiology, genetics, allergy/immunology, and pulmonary diseases.

*We encourage our readers to write opinions on topics of interest. Please send your opinion to Editor, *The Journal*, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

**Dr. Brennan is President of our Camden County component.

***See Doctor Bergen's response to this column on page 463.

The West Jersey Hospital System similarly has provided extensive services to the city and county of Camden. The outpatient clinics at the West Jersey Hospital-Northern Division similarly treat patients regardless of their ability to pay. Approximately 7,000 patients annually visit a total of 14 different clinic services at this facility. The Maldies Eye Clinic is just one of these specialized programs offered to the Camden residents. It extends a special 12-bed eye care unit, and provides the most comprehensive eye services in the entire southern seven county region. Certainly, another one of the valued services provided has been their General Practice Dentistry Residency Program, which operates the dental clinic at Northern Division, and is the only one of its type in this region. In addition to these services, the state's first hospital-based residential alcohol treatment center, "Alcove," is located at Northern Division. Alcove offers a caring, drug-free environment with medical, educational, and psychological counseling for the alcoholic patient.

"The Camden County Medical Society is of the opinion that the health systems in the region should be described as bright."

Much has been said about the demise of the family physician in this age of specialized medicine. However, West Jersey Hospital has made a major commitment to the family practice program. This institution has had one of the first family practice residencies in the area and, in 1978, opened the Tatem-Brown Family Practice Center. As part of the Center, the residency program has its base and is expected to include 18 physicians-in-training by July, 1983.

In addition, the number of community programs in health education, wellness, and affiliations offered by the three institutions are too numerous to list here. While it is accurate that AHEC participated in collaboration with the City Public Health Department that resulted in acquiring primary care physicians in the Camden City area, it actually was through the National Health Services Corps that the additional four physicians were brought to the city's three primary care health clinics. However, Our Lady of Lourdes, CamCare, and Cooper also have availed themselves to National Health Service Corps physicians, the consequence of a Camden City designation as a health manpower shortage area which was accomplished through the City's Public Health Department personnel.

Finally, according to the AHEC budget from October 1, 1982, to September 30, 1983, substantial portions of the budget are allocated to staff and faculty salaries, a comparable allocated cost not to be found in the outpatient clinics at the Camden City hospital-affiliated program.

In conclusion, while it may be true that AHEC has aided this community through some of its efforts, one needs to recognize all of the ongoing efforts by physicians, hospitals, agencies, and other health-care professionals. The "clear mandate of broadly upgrading the health care system of the greater Camden area" was not and is not AHEC's alone. It is our contention that the combined efforts of those health care providers other than AHEC have improved both the access to health care and the outcome of this care for the Camden community and the entire southern New Jersey region. The Camden County Medical Society is of the opinion that the true characterization of the health systems in this region should not be described as "bleak," but rather more properly described as "bright."

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-5]

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Brief Summary: Consult the package literature for prescribing information

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory tract infections including pneumonia caused by *Staphylococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organisms to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by clostridia is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the newborn side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Since Ceclor is administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with enzyme-based tests such as Clinistix®.

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—*Pregnancy Category B*—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in rabbits given three times the maximum human dose, and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.39, 0.21, and 0.11 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are listed below by type and incidence:

Gastrointestinal—Incidence of about 2.5 percent of patients; mostly nausea/vomiting (1 in 40).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform-like rashes (1 in 65). Rashes, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Rare cases of erythema multiforme, Stevens-Johnson syndrome/erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and disappear a few days after discontinuation. Recurrences on rechallenge have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported; half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Clinical Laboratory Test Interactions—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below in order of decreasing information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 100).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

For information on the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever: See package insert or physician's literature.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975
2. Antimicrob. Agents Chemother., 11: 470, 1977
3. Antimicrob. Agents Chemother., 12: 384, 1978
4. Antimicrob. Agents Chemother., 12: 490, 1977
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy) 1: 880, Washington, D.C., American Society for Microbiology, 1978
6. Antimicrob. Agents Chemother., 13: 861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by D. L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487, New York, John Wiley & Sons, 1979

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Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

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Trustees' Minutes April 10, 1983

A regular meeting of the Board of Trustees was held on Sunday, April 10, 1983, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Report of the Executive Director . . .

(1) MSNJ 1983 Paid Membership . . . Noted that a total of 6,416 members paid dues by March 31, 1983, comparing favorably with the March, 1982, figure.

(2) Professional Review Organization Designation . . . Reaffirmed previous position regarding professional review organizations (PSROs).

Note: The Board's position states that PSROs be granted an opportunity to develop a request for proposal under the legislation that would afford a statewide review format acceptable to PSROs, including a provision for MSNJ to serve in a liaison capacity.

(3) The Revised DRGs . . . Noted that copies of an evaluation of the revised DRG format were supplied by Ernst and Whinney; copies can be obtained from 3131 Princeton Pike, Lawrenceville, NJ 08648.

(4) New Jersey Orthopaedic Society . . . Voted to present a resolution of appreciation to the New Jersey Orthopaedic Society in acknowledgment of its generous grant to assist MSNJ in its ongoing projects; the resolution will be announced at the Annual Meeting.

(5) Blue Shield . . .

(a) PACE Program . . . Noted that Blue Shield has requested the State Department of Insurance to approve paying participating physicians at a higher rate than the reimbursement allowed when a patient has chosen a nonparticipating physician.

(b) Major Medical Coverage—Service Benefits . . . Noted that no response has been received from the Department of Insurance regarding questions concerning Blue Shield service benefits for state employees. Noted that Mr. Maressa stated if no action is taken within a reasonable time, he will recommend to the Board: (1) that MSNJ informs the membership of the refusal of Blue Shield to take a responsible action on the issues; and (2) that MSNJ lodges a formal complaint with the Federal Trade Commission on the basis of the failure of the state government to properly evaluate anticompetitive and price fixing potential.

(6) Legislation . . .

(a) No-Fault Insurance Reform . . . Empowered the Executive Committee and the Chairman of the Council on Legislation to meet with the trial lawyers of the New Jersey Bar Association and assume the responsibility for deciding on a mechanism to resolve the medical services reimbursement arrangement under the proposed no-fault legislation.

Report of AMA Trustee . . . Approved the report of James S. Todd, M.D.

(1) AMA Officials . . .

(a) Ad Hoc Committee on Women Physicians in Organized Medicine . . . Congratulated Doctor Formica for her excellent report to the AMA Board of Trustees as Chairperson of the Ad Hoc Committee which gained her the unanimous support for the continuation of the Committee and reappointment as Chairperson.

(b) Trustee . . . Noted that Doctor Todd is a candidate for reelection to the AMA Board of Trustees.

(c) President . . . Noted that Joseph F. Boyle, M.D., and Charles Max Cole, M.D., are candidates for the office of AMA president and are strong individuals.

(2) AMA Activities . . .

(a) Financial Position . . . Noted that the financial position of the AMA continues to be sound.

(b) Direct Membership Option . . . Noted that as a result of the direct membership concept, membership has increased.

(c) Federal Trade Commission . . . Noted that the AMA and Federal Trade Commission have approved language for action by the United States Congress, which gives primacy to state laws in the regulation of the professions.

(d) Regulation of the Department of Health and Human Services . . . Noted that the AMA will file an amicus brief supporting the suit of the American Academy of Pediatrics; the concern is over a hospital requirement to post notices encouraging anyone who thinks an infant is being denied food or customary medical care to call a hotline number.

(e) Professional Standards Review Organizations . . . Noted that Dr. Todd cautioned that groups applying for review designation should have a plan in place by October, 1983.

(f) Consumer Choice in Insurance . . . Noted that free choice of physician and facility from which a patient receives care is stressed by the AMA.

(g) Health Policy Agenda for the American People . . . Noted that the intent of the Health Policy Agenda is to develop a national health policy.

(h) Reports to 1983 AMA House of Dele-

gates . . . Received two reports from Dr. Todd to be considered by the AMA House of Delegates: one report deals with payment for physician services and the second deals with DRGs and cost shifting to private insurers.

i) JCAH Accreditation Manual for Hospitals . . . Noted that the AMA Commissioners on the Joint Commission for Accreditation of Hospitals approved the following:

Continue to delete references to dentists, podiatrists, oral surgeons, and other limited licensed practitioners in the medical staff chapter.

Ensure access to hospitals for limited license practitioners.

Require greater than a majority of fully licensed physican members on the medical staff executive committee in acute care general hospitals. Another principle provides exceptions for other types of hospitals.

Ensure that all hospitalized patients receive the same standard of care through appropriate language relating to admissions and the responsibility for medical care of patients.

Medical Society of New Jersey Student Association . . .

Governor's Budget for Fiscal Year 1984 . . . Approved the following recommendation:

That the Board of Trustees request the Chairman of the Senate Standing Committee on Revenue, Finance, and Appropriations to permit the University of Medicine and Dentistry of New Jersey to retain additional revenue anticipated from the University Hospital to defray tuition increases.

Council on Legislation . . .

(1) Insurance Coverage for Psychiatric Services by Third-Party Payors . . . Voted to approve the following proposed amendment to the Health Insurance Code:

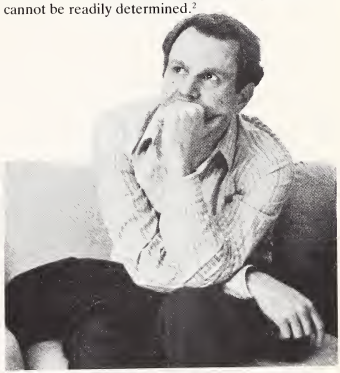
No health insurance contract providing hospital or medical expense benefits shall be delivered, issued, executed, or renewed in this state, or approved for issuance or renewal in this state, by the Commissioner of Insurance, after the effective date of this Act; unless such contract provides benefits to any person(s) covered, thereunder, for expenses incurred in connection with the treatment of mental or emotional illness, when such treatment is provided or prescribed by a doctor licensed to practice medicine in New Jersey. Such benefits shall be provided to the same extent as for any other sickness under the contract.

STATEMENT

This bill would amend the insurance laws to provide that care for mental and emotional disorders shall be reimbursed just as any other medical or surgical treatment for other conditions. Insurance policies in New Jersey limit their coverages for mental and emotional disease without any true justification.

Candidates for nutritional therapy...

5,000,000 hospital patients with infections.[1] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[2]



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THE MULTIVITAMIN/MINERAL FORMULATION

1. Dixon RE: *Ann Intern Med* 89(Part 2):749-753, Nov 1978. 2. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, p. 1114.

Please see summary of product information on reverse page.

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INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

HOW SUPPLIED: Golden yellow, capsule-shaped tablets—bottles of 100.

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This discriminatory action not only stigmatizes the mentally ill patient, it limits his chance for recovery. Mentally and emotionally ill persons deserve equality of insurance coverage for their treatment, To continue the current situation is shortsighted and inhumane.

(2) Establishment of Tactical Network . . . Approved the following recommendation:

That a meeting of representatives from the Board of Trustees, Council on Legislation, JEMPAC, and component and specialty societies be called to establish a tactical network of individuals to implement the followup phase of the legislative process.

(3) Current State Legislation . . . Approved the following recommendation [the list of bills will appear in a forthcoming issue of *The Journal*], with the exception of **S-3045:**

That the Board of Trustees approve the positions recommended by the Council on Legislation.

Council on Medical Services . . .
(1) 1982 Resolution #24E, Discontinuance of Federal Funding of Ambulatory Care Centers, and Resolution #25E, Family Practice Centers . . . Was advised that the Council on Medical Services feels that the fulfillment of Resolutions #24E and #25E best would be addressed at the national level through the AMA and that MSNJ has initiated this course of action.

Council on Mental Health . . .
Prescriptions for Controlled Substances —Manner of Issuance of Prescriptions . . . Referred the following recommendation back to the Council on Mental Health for further study:

That the Board of Trustees advise the Department of Health that the 30-day limitation for filling prescriptions for controlled substances, after the date issued, be expanded to include all drugs.

Council on Public Health . . . Approved the following recommendation:

That the 1983 Eye Health Screening Program be conducted during the week of September 26, 1983.

Correspondence . . . Received and noted the correspondence received from J. Richard Goldstein, M.D., Commissioner of Health, stating his desire for a close association with MSNJ and his hope to attend a Board of Trustees' meeting in the near future.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

A team from the University of Medicine and Dentistry of New Jersey is undertaking the medical surveillance of workers engaged in cleaning up toxic wastes sites in the state. A nine-month, $96,000 contract has been awarded to the Department of Environmental and Community Medicine of UMDNJ-Rutgers Medical School by the New Jersey Department of Environmental Protection.

The project is aimed at detecting and preventing work-related and other diseases among more than 200 workers, mostly 35 years of age and younger, who are employed to clean up the 66 toxic waste sites in New Jersey targeted by the United States Environmental Protection Agency.

The chemical "stew" of waste sites can affect the liver, brain, lung, kidney, and nervous system of the cleanup worker. The worker also must cope with the stress of seen and unseen health hazards.

The medical surveillance project was designed by Bernard Goldstein, M.D., professor and chairman of the department, and Michael Gochfeld, M.D., Ph.S., director of occupational medicine.

Diane Ordin, M.D., M.P.H., an internist with training in occupational medicine, will carry out the surveillance program, which will include medical histories, physical examinations, and laboratory tests. Employees and their regular physicians will be given the results.

The University of Medicine and Dentistry of New Jersey is taking a leading role in identifying a new, mysterious, and often fatal disease called AIDS (acquired immune deficiency syndrome) and transmitting to health professionals and the public what information is available.

Dr. James Oleske, assistant professor of preventive medicine and community health at UMDNJ-New Jersey Medical School, first identified the probable presence of AIDS in children.

In mid-March, the University and Blood Bank Task Force of New Jersey sponsored a well-attended conference on the Newark campus on the subject of "AIDS and Bloodbanking." The possible transmission of AIDS by blood donors has created apprehension, perhaps exaggerated, among hemophiliacs, who require donated blood. Dr. Rajendra Kapila, an AIDS investigator and associate professor in the NJMS departments of medicine and preventive medicine and community health, noted that of 40 AIDS cases at University Hospital, the medical school's core teaching hospital, not one was related to a blood transfusion.

UMDNJ, through its New Jersey School of Osteopathic Medicine, is sponsoring the first genetic counseling program in South Jersey. The Southern New Jersey Perinatal Cooperative, a nonprofit network of 15 hospitals in the seven southern counties, is providing staff support.

With $30,000 in matching grants from the New Jersey State Health Department and the Hunterdon Health Fund, the program will provide genetic counseling to prospective parents, prenatal diagnosis of hereditary disorders, amniocentesis, screening for Tay Sachs disease, and screening and treatment for sickle cell anemia. Dr. Daniel Belsky, D.O., professor and chairman of obstetrics/gynecology at the Camden-based osteopathic medical school, will serve as chairman of the Southern New Jersey Human Genetics Council.

Commencement exercises on May 25, 1983, at the Garden State Arts Center in Holmdel marked an important milestone for nearly 550 students of UMDNJ's six schools. Medical degrees were awarded to 157 graduates of the New Jersey Medical School in Newark, 104 graduates of the Rutgers Medical School in Piscataway and Camden, and 28 graduates of the New Jersey School of Osteopathic Medicine in Camden.

In addition, the New Jersey Dental School awarded 86 dental degrees and the Graduate School of Biomedical Sciences, 13 Ph.Ds. Certificates in a variety of specialties were awarded to 154 graduates of the School of Health Related Professions, Newark.

The theme of this year's commencement was health promotion and disease prevention. The university conferred honorary degrees on Dr. Jean Mayer, president of Tufts University and a world-renowned nutritionist, and Dr. Lena Edwards-Madison, a Jersey City physician. Dr. Mayer delivered the commencement address. Recipient of the University medal was Mr. Frank Kelemen, who is stepping down as board chairman of Cooper Hospital/University Medical Center in Camden. Mr. Kelemen was instrumental in forging the affiliation agreement which seven years ago made Cooper a core teaching hospital of the UMDNJ-Rutgers Medical School.

The university, which deemphasizes organized intramural sports, is sponsoring, along with the Governor's Council on Physical Fitness and the State Health Department, an unusual athletic event in October—a two-day bicycle race.

Sanctioned by the United States Cycling Federation, the invitational competition will have as many as 30 four-member teams pedaling furiously along New Jersey roads. The race will begin Saturday, October 8, 1983, in the Mahlon-Dickerson Reservation area of Morris County, go through Somerset

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County to the UMDNJ-Rutgers Medical School in Piscataway. There, the first day's events will conclude with a separate 20-mile race around University Heights. The second day's racing on Sunday, October 9, 1983, will start from Piscataway, go through Mercer County, and finish at Brookdale Community College in Monmouth County.

Along the way, shorter races called criteriums will be run for women and recreational races open to the public will be held, together with a variety of health promotion activities along the race route. We are calling it the "UMDNJ-Garden State Bicycle Race for Health" and we hope to make it an annual event to encourage health exercise and lifestyle.

Dr. Sugerman Elected Fellow of Royal College of Psychiatrists

A. Arthur Sugerman, M.D., Director of the Affective Disorders Program of Carrier Foundation, Belle Mead, has been elected a Fellow of the Royal College of Psychiatrists.

Dr. Sugerman has served as Medical Director and Director of Research at Carrier Foundation. He is a Clinical Professor at Rutgers Medical School and also is a Visiting Professor at Hahnemann Medical College, Philadelphia.

A member of our Somerset County component, Dr. Sugerman is a Fellow of the American College of Neuropsychopharmacology and of the American College of Clinical Pharmacology.

Dr. Nevins Is Governor of ACP

Michael A. Nevins, M.D., has been elected a Governor of the American College of Physicians (ACP). Dr. Nevins, a specialist of internal medicine, will hold his post as ACP Governor of New Jersey for four years.

As Governor, Dr. Nevins keeps ACP members in his region up to date on policies and activities, advises the ACP ruling body of matters concerning his region, and recruits and endorses new College members and Fellows.

A 1962 graduate of Tufts Medical College, Massachusetts, Dr. Nevins is a Clinical Associate Professor of Medicine at the University of Medicine and Dentistry of New Jersey, Newark. Dr. Nevins is a member of our Bergen County component.

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The American College of Nuclear Physicians, Nuclear Medicine Speakers Bureau, has expert speakers available to speak at any local county medical society or state medical society meeting on the following topics:

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3. The General Relationship Between Radiation Exposure and Medical Illness or Health, from an Individual or Population Standpoint.

For more information, contact, The American College of Nuclear Physicians, 1101 Connecticut Avenue, N.W., Washington, DC 20036.

Physicians Seeking Location In New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Robert M. Klein, M.D., 5959 Delafield Ave., Riverdale, NY 10471. New York Medical College 1976. Subspecialty, pediatrics. Board certified, pediatrics; board eligible, immunology/allergy. Single or multispecialty group, partnership, solo, institutional. Available July 1984.

ANESTHESIOLOGY—Vithal D. Kardani, M.D., 408 Elkin Residence, 5501 North 11th St., Philadelphia, PA 19141. Shah Medical School (India) 1973. Board eligible. Group or partnership. Available

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Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physician Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately, the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

July 1983.

Bharati Mistry, M.D., 74-26 45th Ave., Elmhurst, New York, NY 11373. T.N. Medical (India) 1972. Board eligible. Group, partnership, solo. Available July 1983.

Robert Sackheim, M.D., 200 Carmen Ave., 2B, East Meadow, NY 11554. Guadalajara (Mexico) 1979. Group, fee for service, solo. Available October 1983.

CARDIOLOGY—Amarjeet Singh, M.D., 5579 Glen Hill Dr., Bethel Park, PA 15102. Patiala (India) 1971. Also, general internal medicine. Board certified (IM). Group, partnership, solo, hospital-based. Available July 1983.

DERMATOLOGY—Fred S. Gurtman, M.D., 3760 West Calhoun Pkwy., Minneapolis, MN 55410. Georgetown University (1974). Board certified. Group, partnership, solo. Available.

FAMILY MEDICINE—William J. Rayner, M.D., 616A Country Club Pkwy., Mt. Laurel, NJ 08054. New York Medical College 1975. Board certified. Group. Available July 1983.

David M. Horowitz, M.D., 2201 42nd St., NW, Apt. 103, Washington, DC 20007. NYU 1978. Also, general internal medicine. Board certified. Group or partnership. Available July 1983.

Khaja Naseeruddin, M.D., 409 North Broadway, Apt. 4S, Yonkers, NY 10701. Osmania (India) 1971. Board eligible. Group, partnership, solo. Available.

GASTROENTEROLOGY—N.P. Narayana, M.D., 31 Minebrook Rd., Apt. 169-B, Edison, NJ 08820. Mysore (India) 1971. Also, general internal medicine. Board certified (IM). Partnership, solo, group. Available July 1983.

Joseph S. Tan, M.D., 3221 Bloomfield Lane, #505, Auburn Heights, MI 48057. University of Santo Tomas (Philippines) 1975. Also, internal medicine. Board certified (IM). Partnership, group, solo. Available July 1983.

Michael F. Fina, M.D., 633 Hertford Rd., Winston-Salem, NC 27104. New York Medical 1975. Board certified. Solo (primarily), group or partnership, second choice. Available.

Kailash Chand Singhvi, M.D., 240 Willoughby St., Apt. 10-C, Brooklyn, NY 11201. S.N. Medical College (India) 1977. Also, general internal medicine. Board eligible (IM). Group or solo. Available July 1983.

INTERNAL MEDICINE—Joseph S. Tan, M.D., 3221 Bloomfield Lane, #505, Auburn Heights, MI 48057. University of Santo Tomas (Philippines) 1975. Also, gastroenterology. Board certified. Partnership, group, solo. Available July 1983.

Martin Estok, M.D., 50 Wilson Ave., Newark, NJ 07105. UMDNJ 1980. Board eligible. Group, partnership, solo. Available July 1983.

David Bleeker, M.D., 200 Carman Ave., Apt. 1-C, East Meadow, NY 11554. SUNY-Downstate 1980. Board eligible. Group or partnership. Available July 1983.

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THE MULTIVITAMIN/MINERAL FORMULATION

*Committee on Dietary Allowances, National Research Council: *Recommended Dietary Allowances*, ed. 9. Washington, DC. National Academy of Sciences, 1980, p. 13.

Please see summary of product information on reverse page.

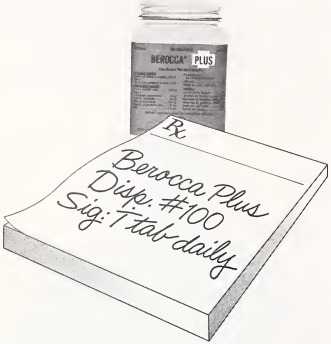
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CONTRAINDICATIONS: Hypersensitivity to any component

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.

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Robert M. Lintz, M.D., 80 High St., Apt. 21-B, Dedham, MA. Jefferson 1978. Subspecialty, gastroenterology. Board certified. Group, partnership, solo. Available.

Helen Feit, M.D., 7-J Drummond, Rocky Hill, CT 06067. SUNY-Buffalo 1980. Board eligible. Salaried position—OPD, clinic, house physician. Available July 1983.

Maureen M. Kelleher, M.D., 85 Fourth Ave., Apt. 7-C, New York, NY 10003. Harvard 1978. Board eligible. Group. Available July 1983.

Arvind Mehta, M.D., 805 North Hanover St., Anaheim, CA 92801. University of Bombay (India) 1975. Subspecialty, nephrology. Solo, partnership, group. Available January 1984.

Amarjeet Singh, M.D., 5579 Glen Hill Dr., Bethel Park, PA 15102. Patiala (India) 1971. Subspecialty, cardiology. Board certified. Group, partnership, solo, hospital-based. Available July 1983.

Kailash Chand Singhvi, M.D., 240 Willoughby St., Apt. 10-C, Brooklyn, NY 11201. S.N. Medical College (India) 1977. Subspecialty, gastroenterology. Board eligible. Group or solo. Available July 1983.

David M. Horowitz, M.D., 2201 42nd St., NW, Apt. 103, Washington, DC 20007. NYU 1978. Special interest, primary care. Board certified (FM). Group or partnership. Available July 1983.

Zakia R. Subhani, M.D., 85 Grant Ave., Colonia, NJ 07067. Liaquat (Pakistan) 1966. Board eligible. Any type practice. Available.

Mircea Cornesco, M.D., 415 E. 64th St., 1J, New York, NY 10021. Inst. of Medicine (Rumania) 1952. Group, partnership, solo. Available July 1983.

Carolyn Ann Rosenberg, M.D., 15704 27th Ave., North, Plymouth, MN 55441. Baylor College of Medicine 1978. Board certified. Group, associate, clinical setting. Available July 1983.

OBSTETRICS/GYNECOLOGY—Kyung S. Cha, M.D., 240 Willoughby St., 6G, Brooklyn, NY 11201. Korea University 1973. Board eligible. Group, partnership, solo. Available June 1983.

Judd Goodman, M.D., 4919 Laurel Canyon Blvd., Apt. 15, North Hollywood, CA 91607. Baylor 1974. Board eligible. Solo or group, preferably in NY metropolitan area. Available.

OPHTHALMOLOGY—Michael Hostovsky, M.D., 4100 West 36th St., Minneapolis, MN 55416. Hadassah (Israel) 1972. Also, neuro-ophthalmology. Board eligible. Single or multispecialty group. Available.

Tariq Saeed, M.D., 6906 Spourse Ct., Springfield, VA 22153. Liaquat College (Pakistan) 1968. Board eligible. Group, partnership, solo. Available July 1983.

OTOLARYNGOLOGY—Richard Schiffman, M.D., 2717 East 28th St., Brooklyn, NY 11235. Tufts 1977. Board eligible. Partnership or group. Available.

PATHOLOGY—Siamak Shokri-

Tabibzadeh, M.D., Montefiore Hospital and Medical Center, 111 E. 210th St., Bronx, NY 10467. Tehran (Iran) 1977. Academic institution. Available.

Marvin N. Solomon, M.D., 3 Sutliff Ave., Vineland, NJ 08360. Berne (Switzerland) 1937. Special interest in anatomic and forensic. Board certified (P.A); board eligible (forensic). Hospital staff, locum tenens. Available.

Pushpa Gupta, M.D., 100-C Thorndale Dr., Dayton, OH 45429. S.N. Medical College (India) 1971. Any type practice. Available.

PEDIATRICS—Steven Lewis Perrick, M.D., 17 Paerdegat 11 St., Brooklyn NY 11236. SUNY-Downstate 1980. Board eligible. Partnership, solo, group. Available July 1983.

Harvey A. Hirsch, M.D., 137-03 70th Rd., Flushing, NY 11367. Guadalajara (Mexico) 1978. Associate, group, partnership, HMO. Available July 1983.

PULMONARY DISEASES— M. Zaslow, M.D., 24 Westgate Rd., Chestnut Hill, MA 02167. Harvard 1977. Also, general internal medicine. Board certified (IM); board eligible (PM). Any type practice. Available.

RADIOLOGY (DIAGNOSTIC)—A. Rama Subramaniam, M.D., 186 Ellery Ave., P.O. Box 6189, Newark, NJ 07106. Stanley Medical College (India) 1964. Special interest, nuclear medicine. Solo, group, partnership, academic, hospital-based practice. Available July 1983.

SURGERY, GENERAL—Carlos A. Ferrari, M.D., 741 E. Tuscarawas, Barberton, OH 44203. Univ. National of Cordoba (Argentina) 1972. Board certified. Solo, small group, partnership. Available August 1983.

Matthew K.Y. Mo, M.D., 38123 Jamestown Dr., Sterling Heights, MI 48077. China Medical (Taiwan) 1974. Also, vascular surgery. Board eligible. Any type practice. Available July 1983.

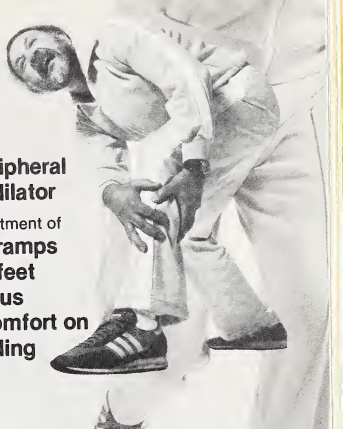
SURGERY, THORACIC—John P. Hubert, Jr., M.D., 33 Viking Village, N.W., Rochester, MN 55901. Minnesota 1975. Board certified. Private practice or single specialty in small group. Available July 1983.

SURGERY, VASCULAR—John P. Hubert, Jr., M.D., 33 Viking Village, N.W., Rochester, MN 55901. Minnesota 1975. Board certified. Private practice or single specialty in small group. Available July 1983.

Matthew K.Y. Mo, M.D., 38123 Jamestown Dr., Sterling Heights, MI 48077. China Medical (Taiwan) 1974. Also, general surgery. Board eligible. Any type practice. Available July 1983.

UROLOGY—V.P. Nagarajan, M.D., 61 Maple Ct., Apt. 4, Snyder, NY 14226. Tirunelvel (India) 1973. Solo, group, partnership. Available July 1983.

Gary Neal Dunetz, M.D., 310 LaGrange St., Chestnut Hill, MA 02167. SUNY-Upstate 1977. Group, partnership, multispeciality group. Available July 1984.



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LETTERS TO THE EDITOR

Health Care in Camden County

April 5, 1983

Dear Doctor Krosnick:

Dr. Brennan, of course, is correct in pointing out the tremendous strides made in recent years in improving the health status of Camden County citizens (see page 451). The point I tried to make in my UMDNJ column to which he refers was exactly that. Perhaps it is understandable that I should highlight the role UMDNJ has played in this improvement, largely through the Area Health Education Centers program which the federal government and UMDNJ jointly are funding for precisely this purpose.

I am sorry if, in attempting to bring attention to the University's efforts in Camden County, I have seemed to slight the very real and continuing contributions of members and colleagues of the Camden County Medical Society. Indeed, the modus operandi of an AHEC is cooperation with existing health professionals and institutions—in this case, with the physicians, dentists, hospitals, and allied-health professionals of South Jersey. All share the same goals—continued improvement.

Please accept this University's commitment to continued cooperation with all our Camden-area colleagues in this regard.

(signed) Stanley S. Bergen, Jr., M.D.

Fifth Pathway

March 24, 1983

Dear Dr. Krosnick:

As Dr. Mariano's response to our paper (November, 1982) is one of only three received, we are left in doubt whether it was generally approved or found unimportant. Letters of angry disappointment such as his do not need solicitation. So, despite its misquotations and non sequiturs, I am grateful for the opportunity Dr. Mariano's letter (April, 1983) provides for further comment.

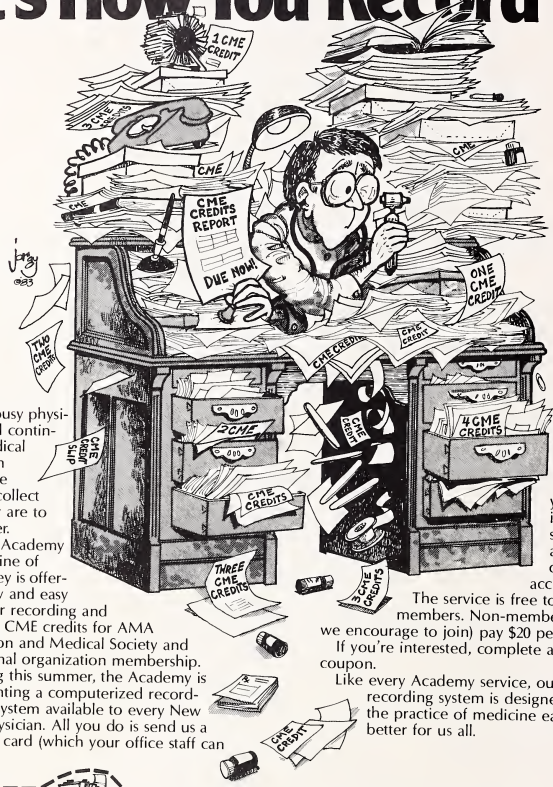
"New Jersey's Fifth Pathway" was presented virtually in its present form before the New Jersey Health Sciences Group in December, 1981. The other two speakers were Dr. Stanley S. Bergen, Jr., President of the University of Medicine and Dentistry of New Jersey, and Dr. Edward Cohen, Assistant Chancellor for Health Professions Education, State Department of Higher Education. The general topic was oriented toward the development of state policy, vis-à-vis undergraduate and graduate training and licensure in New Jersey for United States students studying medicine abroad. At the conclusion of the session, it was suggested that the discussion be submitted for publication in *The Journal*.

A prevalent and persistent view which was presented at the meeting is that a program should be developed which would bring USFMGs as a whole to the level of performance of United States graduates as a whole. The point of my discussion was that, if licensure is taken as a final criterion in this respect, experience has shown that Fifth Pathway graduates meet it to a considerable degree. Further, that they had populated New Jersey first-year residencies at a greater rate than either of the two state medical schools. However, it was shown that if more refined credentials in the form of specialty certification were set as criteria, a large variation is exposed which cannot be attributed to differences in training. Therefore, it was suggested, policymakers are obliged to decide what they want in the end and face the necessity of selecting what they cannot create. There is nothing original about this. It is well known that outstanding institutions of learning have outstanding graduates in good part on the basis of their selection of matriculants. We referred to two well-documented, but unpublished, studies, not to support this well-known truth, but to provide collateral illustration of it in a related context. Incidentally, nowhere in our paper do the words "inferior" or "reject" appear.

Dr. Mariano refers to FMGs "whose responsibilities as Fifth Channel students were nothing more than that of observers with very little 'hands on' experience." This in no way describes the experience of New Jersey Fifth Pathway students, as the directors of the program at each participant hospital and the students themselves readily can testify. In fact, the larger concern of some preceptors was that these students were functioning much more as interns than as domestic fourth- or third-year clinical students. As for the difference between the New York and New Jersey experience, one of the epistolary responders to our article is an experienced director and evalutor of the New York Fifth Pathway programs. In commenting on our observations, he stated that the New York experience was similar to ours.

(signed) Gordon N. French, M.D.
Director, Fifth Channel Program

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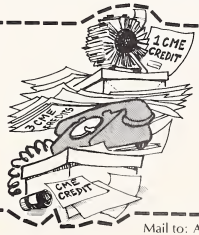
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CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, The Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For informaton on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

NEUROLOGY/PSYCHIATRY

July

4 **Psychiatric Case Conferences**
11 7:30-11:30 a.m.—Trenton Psychiatric
18 Hospital
25 *(Trenton Psychiatric Hospital and AMNJ)*

6 **Child Psychiatry Case Conferences**
13 10 a.m.-12 noon—Trenton Psychiatric
20 Hospital
27 *(Trenton Psychiatric Hospital and AMNJ)*

7 **Sexual Dysfunction: Update 1983**
14 **Alzheimer's Disease and Family Dynamics**
21 **Strategies To Break Through Psychotic Isolaton**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

Aug.

1 **Psychiatric Case Conference**
8 7:30-11:30 a.m.—Trenton Psychiatric
15 Hospital
22 *(Trenton Psychiatric Hospital and*
29 *AMNJ)*

3 **Child Psychiatry Case Conference**
10 10 a.m.-12 noon—Trenton Psychiatric
17 Hospital
24 *(Trenton Psychiatric Hospital and*
31 *AMNJ)*

4 **Hypnosis: Update on Diagnosis and Treatment Issues**
11 **Mood Disorders in Children and Adolescents**
18 **Creative Arts as Therapy**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

RADIOLOGY

July

1 **Basic and Advanced Echocardiography, and Real-Time, Cross-Sectional Sector Scanning**
Sands Hotel & Casino, Atlantic City
(The National Foundation for Noninvasive Diagnostics and AMNJ)

SURGERY

July

6 **Surgical Departmental Conferences**
13 8:30-10 a.m.—Rutgers Medical School,
20 New Brunswick
27 *(UMDNJ)*

Aug.

3 **Surgical Departmental Conferences**
10 8:30-10 a.m.—Medical Educ. Bldg.
17 Rm. 108, Rutgers Medical School,
24 New Brunswick
31 *(UMDNJ)*

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastics, and Vascular Surgery)

July

7 **Vascular Conference Rounds**
14 4-5 p.m. Rutgers Medical School,
21 New Brunswick
28 *(UMDNJ)*

Aug.

4 **Vascular Conference Rounds**
11 4-5 p.m.—Medical Educ. Bldg. Rm. 593, Rutgers Medical School, New Brunswick
(UMDNJ)

***The Journal* of the Medical Society of New Jersey**
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September, 1983

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OBITUARIES

Dr. William N. Alexander

Word has been received from our Burlington County component of the death of William Newton Alexander, M.D., on March 20, 1983. Dr. Alexander, a psychiatrist, practiced in the Willingboro area until 1977 when he returned to the state where he was born, Montana, but maintained affiliate membership in the Medical Society of New Jersey. He received his medical degree from Jefferson Medical College in 1956 and had been affiliated with Rancocas Valley Hospital, Willingboro, and the Eastern State School and Hospital in Trevose, Pennsylvania. Dr. Alexander was 62 years old at the time of his death.

Dr. M. Hugo Assante

On April 3, 1983, Mario Hugo Assante, M.D., died at the age of 75. A graduate of Jefferson Medical College, Pennsylvania, in 1935, Dr. Assante was affiliated with Cooper Medical Center, Camden, and West Jersey Health System, Berlin. Dr. Assante was a member of our Camden County component and of the American Medical Association.

Dr. Xavier B. Budnicki

On March 22, 1983, Xavier B. Budnicki, M.D., a member of our Middlesex County component died in Perth Amboy General Hospital. Born in 1919, Dr. Budnicki was graduated from Georgetown University Medical School in 1945. He spent the next two years serving with the medical corps of the United States Army. Dr. Budnicki returned to his birthplace, Perth Amboy, where he practiced surgery for 34 years, and served on the staff of Perth Amboy General Hospital. He was the municipal physician for Perth Amboy for 18 years. Dr. Budnicki was a Fellow of the American Society of Abdominal Surgeons, a Fellow of the American Academy of Compensation Medicine, and a member of the American Medical Association.

Dr. Maurice A. Chodosh

Maurice Allen Chodosh, M.D., an affiliate member of our Union County component, died on February 6, 1983. Born in 1911, Dr. Chodosh earned a medical degree at the University of Virginia Medical School in 1937. During his career, Dr. Chodosh was affiliated with Alexian Brothers Hospital and Elizabeth General Medical Center, both in Elizabeth. Dr. Chodosh was a member of the American Medical Association and a Fellow of the American Academy of Family Practice.

Dr. Michael J. DeMattia

At the age of 81, Michael Joseph DeMattia, M.D., died on March 3, 1983. Dr. DeMattia received his medical degree from the University of Naples in 1919. A family practitioner, Dr. DeMattia was a member of our Passaic County component and of the American Medical Association. Dr. DeMattia was affiliated with General Hospital, Wayne. In 1969, Dr. DeMattia received MSNJ's Golden Merit award.

Dr. Isador Gittelsohn

Isador Gittelsohn, M.D., a recipient of MSNJ's Golden Merit Award in 1979, died on March 7, 1983. Born in 1906, Dr. Gittelsohn received a medical degree from Long Island College of Medicine, New York, in 1929. A family practitioner, Dr. Gittelsohn was affiliated with Pascack Valley Hospital, Westwood, and Hackensack Hospital. Dr. Gittelsohn was a member of our Bergen County component and of the American Medical Association, and was a Fellow of the American Academy of Family Practice.

Dr. Isidore Goldberg

Isidore Goldberg, M.D., died on March 14, 1983. Born in 1901, Dr. Goldberg earned a medical degree from the University of Maryland in 1927. A member of our Middlesex County component and of the American Medical Association, Dr. Goldberg was affiliated with Muhlenberg Hospital, Plainfield, and Raritan Hospital, Greenbrook. Dr. Goldberg was a recipient of MSNJ's Golden Merit award.

Dr. John E. Morehead

John Elwood Morehead, M.D., a member of our Union County component, died on April 8, 1983. Born in 1922, Dr. Morehead earned a medical degree at Jefferson Medical College, Pennsylvania, in 1953. As a family practitioner, Dr. Morehead was affiliated with Muhlenberg Hospital, Plainfield. Dr. Morehead was a member of the American Medical Association.

Dr. Vito N. Palumbo

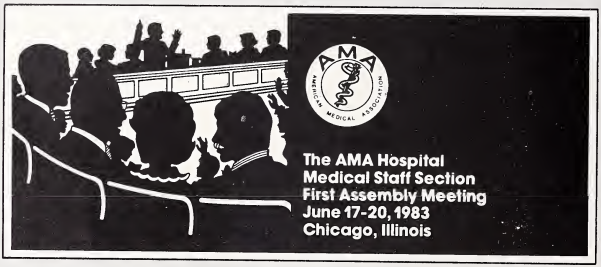
At the untimely age of 50, Vito Nicola Palumbo, M.D., died on March 4, 1983. Dr. Palumbo was graduated from Faculty of Medicine University of Rome, Italy, in 1956. He was affiliated with Muhlenberg Hospital, Plainfield. Dr. Palumbo was a member of our Union County component and of the American Medical Association, a Diplomate of the American Board of Pediatrics, and a Fellow of the American Academy of Family Practice.

Dr. V. Raymond Tokar

Vincent Raymond Tokar, M.D., a member of our Essex County component died on April 5, 1983. Born in 1915 in Passaic, Dr. Tokar earned a medical degree from New York Medical College in 1942. He was an ophthalmologist in Montclair for 29 years. Dr. Tokar was affiliated with The Mountainside Hospital and Community Hospital, both in Montclair. A member of the American Medical Association, Dr. Tokar also was a Diplomate of the American Board of Ophthalmology.

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BOOK REVIEWS

Current Clinical Topics in Infectious Diseases

Jack S. Remington, M.D., and Morton N. Swartz, M.D. New York, NY, McGraw-Hill Book Co., 1982. Pp. 397. ($35)

The editors of *Current Clinical Topics in Infectious Diseases* are extremely successful in selecting topics that are current and clinical; also, the chapter contributors write with completeness and accuracy.

Individual chapters deal with very recent problems, such as, sexually transmitted diseases with emphasis on enteric infections, the role of ultrasound and CT scans in the diagnosis and treatment of intraabdominal abscess, the prophylaxis and treatment of malaria, the newer antifungal agents, candida endophthalmitis, and cutaneous leishmaniasis. Older topics discussed are Guillain-Barré syndrome, "atypical" mycobacteria, total hip replacement infections, primary and secondary drug treatment for gram-negative sepsis, intravascular line infections, and meningitis due to CSF leaks.

Updating older-new problems are the chapters on antiviral agents such as interferon and nucleoside derivatives, amphotericin and 5-flucytosine, bacterial meningitis in children, and the use of prophylactic antibiotics for bowel surgery.

All the chapters uniformly are well-written and the information is detailed, complete, and accurate. The bibliographies are extensive and up to date. Charts and illustrations are plentiful and excellent. Particularly outstanding are the chapters on sexually-transmitted enteric diseases, nucleosides, antifungal agents, and intravascular line infections. The chapter on malaria emphasizes properly the lack of MD-awareness, diagnostic pitfalls, chloroquine-resistant falciparum, and inadequate prophylaxis.

This is a well-written book on selected infections and infective situations; it is a valuable reference work and, as such, belongs in a medical library or in the hands of those with a special interest in infectious diseases.

Dominic Mauriello, M.D.

Communication Skills for the Foreign-Born Professional

Gregory A. Barnes. Philadelphia, PA, ISI Press, 1982. Pp. 198. Illustrated. ($13.95 softback; $18.95 hardback)

Gregory A. Barnes has written an excellent "how-to-do-it" book for professionals whose second language is English. This treatise is one of the Professional Writng Series published by ISI Press.

Communication Skills for the Foreign-Born Professional contains four parts: verbal and nonverbal communication; reading effectively in English; basic principles in writing English; and guidelines for writing in the professions. Although Parts I and II are very valuable, as an editor, I found Part IV of the most interest and Appendix II (mechanics of writing) and Appendix III (grammar handbook) extremely useful.

Barnes, who assumes the position that "communication is the principal function of the professionally trained" takes nothing for granted except an ability of the reader to read. In Chapters 5 through 8, however, he expands on this basic assumption and provides a foundation and a bagful of communication pearls.

The author's division of the composition with an introduction, body, and conclusion, is standard, but potential authors who heed his advice as to how to prepare each section will make editors happy. Too often, inexperienced writers intermingle ideas from one part to another in a confusing manner. He suggests that the inexperienced writer seek help from professional colleagues and societies when needed before starting on a paper, rather than expecting the staff of the publication to rewrite the manuscript. The literature review is a bit simplified and does not describe in detail the use of the electronic data sciences such as the Medlars-Medline System of the National Library of Medicine.

Brief paragraphs define the actual writing of the scientific paper, using a standard organization (introduction, materials and methods, results, discussion, and conclusions). Barnes recommends that the author select a journal carefully, heed that publication's "Instructions to Authors," carefully proofread the typed manuscript, and accompany the final copies with a covering letter to the editor. It would be a joy if everyone did that!

Appendix I is a series of exercises that test the reader's understanding of each chapter, while Appendix II and especially Appendix III should be required reading for the physician who is inexperienced with writing for a medical journal, whether English is a first or second language.

I recommend this book for medical students, residents, fellows, and practitioners whose second language is English. It will help in all types of writing—letters, reports, hospital charts, and other mundane writing chores as well as articles for medical journals.

A.K.

Diabetes Mellitus and Obesity

Bernard N. Brodoff, M.D., and Sheldon J. Bleicher, M.D., (eds). Baltimore, MD, Williams and Wilkins Company, 1982. Pp. 816. ($60)

This is not a textbook of diabetes but rather a tome of scholarly essays on every aspect of obesity and diabetes by authors expert in their respective fields. Using not didactic instruction, but a review of all theories and laboratory findings (supportive as well as contradictory or confusing), the authors develop their subjects fully. The essays form a link between the laboratory and the clinician.

In obesity, the discussions develop from studies of the fat cell, through essays on spontaneous development of obesity and diabetes in animals, to the

development of both conditions in humans. The point is made that obesity in children due to overfeeding results in an increase in the number of fat cells. In contrast, in adults overfeeding results in an increase in size of the individual fat cell. This tends to explain why reduction to normal weight in adult onset diabetes relieves the diabetes, while reduction in ideal normal weight may be unnecessary and inappropriate goals for the diabetic whose onset of obesity is in childhood. The latter normalizes fat cell size while still not an ideal weight, because of the increase of the number of fat cells. Therefore, the patient will level diabetes while still somewhat overweight. The author points out that the aura of failure associated with the treatment of obesity is because the great number of obese childhood onset, rather than adult onset, patients present in most weight reduction clinics.

It also is interesting that the juvenile onset obese patients experience some symptoms of anxiety and depression, concern over changes in body size and configuration, and preoccupation with food and vigor during reduction, and these feelings continue after they return to a maintenance diet. In contrast, the adult onset obese shows no increase in depression nor anxious symptoms after undergoing weight reduction. Much because the same concern over body configuration is found, the editors include a fine essay on anorexia nervosa. No new treatment for obesity is propounded but dieting, behavior modification, and the various surgical procedures for weight reduction are discussed in depth.

Diabetes is explored thoroughly from a lucid explanation of genetics through the epidemiology, pathology, complication, and treatment of both insulin-dependent and noninsulin-dependent diabetes. There is an excellent chapter on control. While urine testing, with all its imperfection, still is advocated, home-glucose monitoring is recommended as a more precise guide to development and maintenance of the best possible therapeutic regimen and control. However, it is warned that this is no panacea. The most common problem with the overzealous use of insulin to achieve a precise goal of normoglycemia is the danger of hypoglycemia. Dr. Danowski's system of split-dose intermediate insulin, supplemented by a dose of regular insulin by Syrijet according to home-glucose blood test before meals, has much to recommend it in the treatment of severe insulin-dependent diabetics.

There are chapters on pregnancies in diabetic mothers as well as chapters on their infants. An interesting addition to the discussion of complication of diabetics is an entire chapter on the oral complication. All the newer treatments are discussed fully, ranging from organ replacement in endstage kidney disease to pancreatic transplant, islet cells transplant, and pumps. Insurability and employability of diabetics is a useful practical chapter for the practicing physician.

This volume is not a book for quick reference for the busy physician, nor a text for the medical student. However, it is recommended strongly as a reference text for the serious student of diabetes or the practicing diabetologist, who desires a complete discussion of current concepts.

Samuel E. Einhorn, M.D.

Doctor Bernard de Gordon, Professor and Practitioner

Luke E. Demaitre. Toronto Pontifical Institute of Mediaeval Studies, 1980. ($18)

Following closely on Salerno as the earliest center of medical education in the West is the school of Montpellier in the south of Provence. By the end of the 13th century, it had reached a peak of leadership, attracting students from all parts of Europe. Among these were such celebrities as Gilbert the Englishman, the Majorcan Raymond Lull, the Catalan Arnold of Villanova, and the famous Guy de Chauliac, one of the fathers of European surgery. However, it is the writer Bernard de Gordon, the subject of the present volume, who was to bring the school its greatest glory through his influential work, the famous *Lilium Medicinae* of which no less than 50 manuscripts exist as well as numerous translations into Latin and foreign languages. Seldom has so much homage been given to a single text that was to continue in active use until the end of the 17th century.

Professor Demaitre has proved conclusively that Gordon was not a Scotsman as was long thought, but a Provencal who spent his whole life teaching and practicing at Montpellier. Although a true adherent of Gallen, Bernard was not a slavish follower of the Master but insisted on his own observations and did not hesitate to differ with the authorities. Among the clinical entities which he described with some thoroughness were epilepsy, scabies, trachoma, tuberculosis, and other contagious diseases. He is noted for his first description of a truss for inguinal hernia and often is credited with the first use of eyeglasses or magnifying lenses. Demaitre's book is a scholar's delight although eminently readable, but he does not neglect Bernard's interest in the lunar cycle for predicting the proper days for administration of medicines and for phlebotomy. In other words, Bernard was a man of his times who managed to add only a modicum to the beginnings of the scientific method. The book is highly recommended to all humanist physicians interested in their medieval past.

Morris H. Saffron, M.D.

Drug Therapy in Obstetrics and Gynecology

William F. Rayburn, M.D., and Frederick P. Zuspan, M.D. Norwalk, CT, Appleton-Century-Crofts, 1982. Pp. 401. ($38.50)

This text is a much needed and valuable book for the obstetrician-gynecologist. It is recommended for reading and reference with the rejoinder that even the most recent publications must be updated with ever-changing information, since they very quickly become obsolete.

The therapeutic regimes and agents available today make it mandatory to be familiar with the actions, reactions, and interactions of the drugs in use. The book is easy reading and most informative. The index is a comprehensive one and makes the book usable for reference.

Drugs used in obstetrics are presented in the first part. There are chapters on drug effects on the fetus, inhibition with drugs in premature labor, and drugs in the breast milk.

Part II is the use of drugs in gynecology. There are chapters on the induction of ovulation, the treatment of vulvo-vaginal problems, and the treatment of endometriosis.

The third part is on the use of certain pharmacologic medication in the treatment of extra ob-gyn conditions. This section will prove valuable to those of us who are primary care physicians and treat conditions which are managed by us and do not require referral to our associate other specialty physicians.

The appendix contains a most useful compilation of drug interactions which should be very advantageous to have. I was happy to see that some of the preparations named also were labeled with their proprietary name plus the generic

name. This is contrary to what I was taught in pharmacology but it makes recognition of the preparation one is using much easier. I recommend this text to the specialist who wants to keep current and also have a source from one place.

Earl Kanter, M.D.

Dynamic Psychiatry in Theory and Practice

Edwin R. Wallace, IV, M.D. Philadelphia, PA, Lea & Febiger, 1983. Pp. 407. ($30)

This work is a rare treat, a refreshing contrast to the flood of publications that promise instant cures by innovative sleight of hand. The author presents the theoretical framework and the practice of psychoanalytic psychotherapy in a lively and understandable style. Clarity without oversimplification is a difficult feat in such a complex field, yet Dr. Wallace accomplishes this task admirably.

There is a comprehensive introduction for the mental health trainee and the volume has an important section on evaluation, including mental status examination, formulation, and diagnosis. As a necessary preliminary to treatment considerations, the basic need for gathering data about the patient is stressed. Again, we are reminded of the world of difference from the books touting indiscriminately applied panaceas.

The numerous case illustrations make the text vivid and meaningful. Thoughtfulness is evident throughout. Dr. Wallace emphasizes the importance of subordinating theory and technique to personal and clinical experience, reminding the reader of both sides of the equation.

Dr. Wallace defines dynamic psychiatry as a historical and interpretive method for the study and therapeutic transformation of interpersonal relations. He sees it as the most holistic model in psychiatry, dealing with the biopsychosocial unity of the human being.

This outstanding text stands on its own merits, and also serves as a counterbalance to the one-sided presentations of social, biological, and pharmacological approaches to the patient.

Leonard Hollander, M.D.

Textbook of Medicine, 16th Edition

James B. Wyngaarden, M.D., and Lloyd H. Smith, M.D., (eds). Philadelphia, PA, W.B. Saunders Company, 1982. Pp. 2,707. ($75)

Textbook of Medicine is the 16th and latest addition to a very distinguished line of textbooks. "Cecil" is one of the two leading authorities on this subject. The new coauthors feel this massive book—25 parts, over 2,500 pages—is at a limit for a single volume.

The book is extremely correct and comprehensive. Rather than enlarge or add new parts, the authors have added two new books to the series, one on pathophysiology and the other on microbiology and infectious diseases. There also is a question and answer review book as a companion to this large tome.

I could not read this book entirely cover-to-cover and expect it to be unlikely anyone ever does. The book should be owned and available where a doctor at any stage of experience will have frequent occasion to delve into its multiple delights. The chapters are short and very concise. What joy for a clinician to look something up for ten minutes and then slam homers back to back while on rounds with students and house staff! I always liked "Cecil" better and consider this volume the best yet in the series.

Norman Riegel, M.D.

Urinary Tract Infections in Children

Stanley Hellerstein, M.D. Chicago, IL, Year Book Medical Publishers, 1982. Pp. 139.

Dr. Hellerstein has produced a compact, up-to-date volume on the diagnosis and management of urinary tract infections in children. It is an excellent summary of the available data. In particular, I found the discussion on the important entity of vesicoureteral reflux extremely informative with excellent comments on management.

The chapter on the localization of urinary tract infections also was very readable and contained the most recent information.

Personally, I did not find the illustrations in Appendix II, of the urinary sediment with phase microscopy, particularly helpful.

In general, *Urinary Tract Infections in Children* is an excellent volume; however, I question the need for it since virtually all the information is available in the standard textbooks.

Robert Dodelson, M.D.

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2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis.* New York, NY, McGraw-Hill, 1969, Pp. 42-48.

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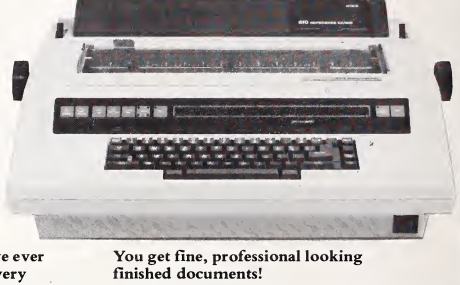
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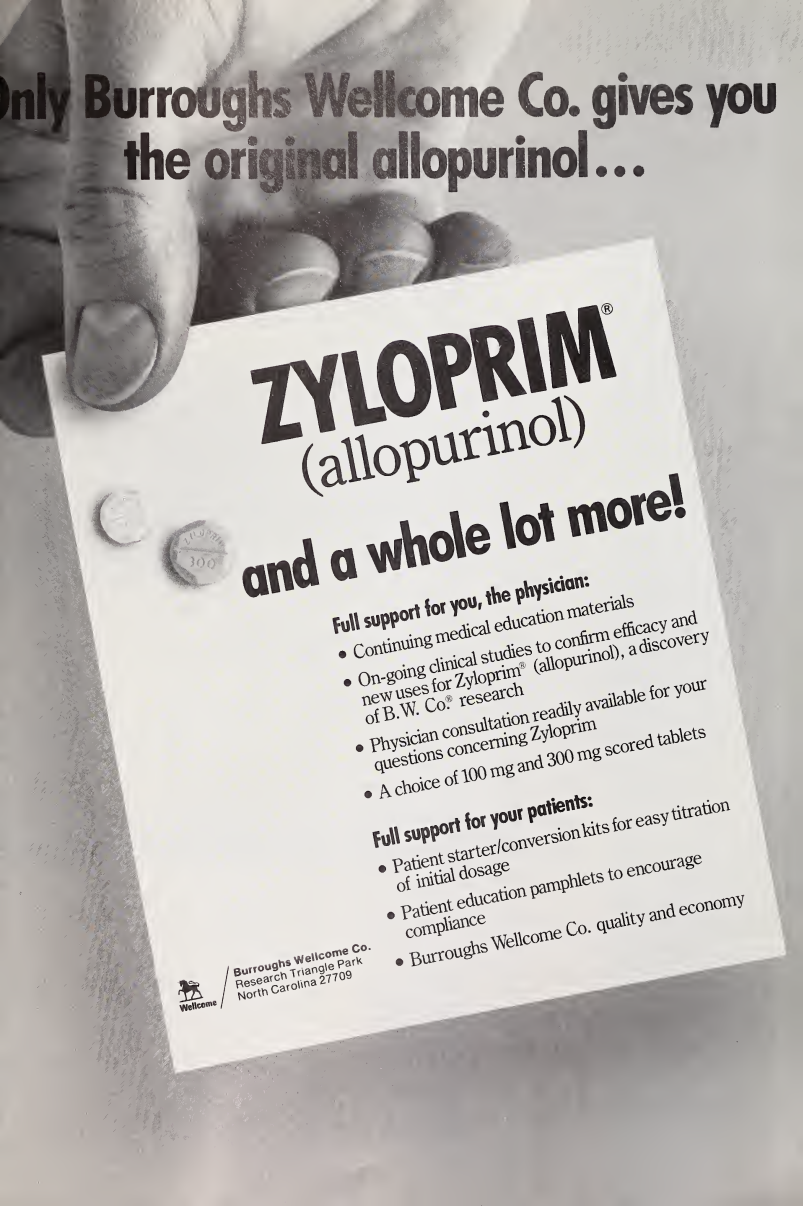
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On The Cover: The Staghorn Sumac presents an intriguing pattern. Although it is a member of the anacardiaceae, along with poison sumac, poison ivy, and poison oak, this species is nontoxic. For an editorial on the mischievous members of the *Rhus* family of plants turn to page 497. The cover photograph is by Owen A. Shteir, M.D., a member of our Mercer County component.

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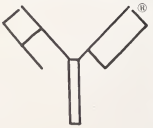
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MEMBERSHIP NEWSLETTER

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THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 1

MEDICAID RULE CHANGE

The Division of Medical Assistance and Health Services is proposing a rule which will define more clearly an emergency, and indicate the type of documentation required when a provider submits a claim based on an emergency.

There are two types of "emergencies." One is the standard "medical emergency," that should be supported by appropriate documentation. The nature of the case, and services rendered, if documented, should be sufficient to meet this definition. The second type of emergency is an "administrative emergency," that could occur when prior authorization could not be obtained from the Medicaid District Office. Retroactive authorization may be obtained by submitting appropriate documentation to the Medicaid District Office within five calendar days after the service was provided.

HEALTH INSURANCE FOR THE UNEMPLOYED

In testimony before Committees of the House of Representatives and the Senate, the AMA addressed the national problem that exists because millions of unemployed persons have lost their employer-based health insurance coverage, cannot afford to purchase private health insurance, and do not qualify for government health programs. The AMA advocated the establishment of a temporary program that would provide limited health benefits to the unemployed. The Association stated that the program should be administered in the private sector and provide private insurance coverage with freedom of choice of provider. Financing should be shared between the government and the private sector.

BEWARE

Bogus safety bulletins are being circulated throughout the country alleging that contact lens wearers have been blinded from industrial sparks, the American Academy of Ophthalmology reported. The anonymous fliers have been distributed to the United Auto Workers, Civil Service Employees Assn., Genstar Stone Products Co., Baltimore Police Dept., Maryland Dept. of Transportation, and U.S. Air Force. The notices claim that electric sparks or flashes caused the workers' contact lenses to fuse to the cornea. Bruce E. Spivey, M.D., the Academy's executive director, said the alleged eye damage was impossible medically. The ophthalmology group is urging companies to remove the false alerts from bulletins boards or from further circulation among workers.

CLOSED CIRCUIT TV

The Health Research and Educational Trust (HRET) of the New Jersey Hospital Association and MSNJ have joined together to promote the Healthcare Information Network, a nonprofit, closed-circuit television network.

MSNJ, as a participant and financial contributor, is entitled to a minimum of two hours of network time each month. Programs related to issues and concerns of physician members of MSNJ, as well as CME programs related to the practice of medicine, are in the planning stages. These programs will emanate from HRET studios in Princeton in September and will have the added feature, via telephone lines, of communication between the presentor and the viewer.

The statewide Healthcare Information Network will be a first of its kind nationally and represents an exciting move toward the role of a 21st-century communicator for the health care providers of New Jersey.

For further information regarding the Healthcare Information Network, please contact Mr. Ron Rouse, Director, Special Projects, MSNJ Executive Offices, Lawrenceville.

JEMPAC POLITICAL FORUM

When Senator Howard Baker, majority leader of U.S. Senate, announced he would not seek reelection he undermined his leadership position and that of the

Republican Party. Senators Robert Dole and Bob Packwood, vying for the leadership position, have brought about fragmentation within the party and a further loss of a power base.

These cogent remarks regarding the Washington political scene were part of the address given by Peter Lauer, Executive Director of AMPAC, at the JEMPAC Political Forum held during MSNJ's 1983 Annual Meeting in Atlantic City.

Mr. Lauer, who has been with AMPAC for eight years, discussed the current presidential hopefuls. Mr. Lauer offered the following: Mondale is the frontrunner, an anti-PAC candidate, who is attempting to be all things to all people; Senator Glenn has a good organization, and with the release later this year of the movie "Right Stuff" (which depicts John Glenn, the astronaut, as "Mr. Apple Pie,") Glenn's popularity will strengthen; Senator Hart is the "new democrat" who believes in a coalition of government and business and remains at the opposite end of the Kennedy philosophy of government; Ernest Hollings, former governor of South Carolina, looks and sounds like a president, but the Carter image will hurt his chances; and Rubin Askew from Florida, suffers from the same Carter image and will drop out early after the New Hampshire primary.

As to the Republican candidates, Mr. Lauer believes President Reagan will seek reelection. The only thing that might hurt the President is if some groups or media organization begin to poll the constituents as to whom they would like to see as the Republican candidate if President Reagan decides not to run. Should Bush, Dole, Packwood, or Kemp receive a 35 percent or better total in such a poll, then a race could develop for the top spot within the party, and only add to party fragmentation.

Addressing the critics of PACs, Mr. Lauer branded the remarks made by Mr. Nader's organization and Common Cause as "innuendos, lies, and distortion." These groups perceive "PACs as a monolith marching down Pennsylvania Avenue or the streets of the state capitals." There are 3,500 PACs, each with 3,500 different philosophies. Sometimes a few PACs may join together on an issue, but not as a matter of fact "as critics would have the public believe."

Critics of PACs claim that legislators are influenced by PAC contributions, thus their votes on issues are not based on facts, but on how much was contributed to their campaigns. "If these groups believe Congress or the State Legislature is up for sale—prove it, turn in the names of such individuals to an ethics committee," challenges Mr. Lauer.

Critics have stated that Congress is in disrepute because of PAC persuasive influence. "I say Congress is in disrepute because of tax breaks voted for members of Congress without public awareness; because of pay raises voted for Congress by Congress; because of Abscam; and because of alleged drug and sex scandals," charged Mr. Lauer.

In his closing remarks, Mr. Lauer encouraged physicians to join JEMPAC/AMPAC where members have a voice in candidate support. "Government believes it has a right to practice medicine—you have a right to practice government."

THE SOLO PRACTICE

The solo practice of medicine, as it is known today, will go the way of the dinosaurs in five to ten years, according to Burton L. Eichler, J.D., and William Kane, M.D., Vice-President for Medical Affairs at Burlington County Memorial Hospital.

These two spokesmen were participants in a program sponsored by MSNJ entitled "Corporate Practice of Medicine and the Private Practice of Medicine."

The seminar was held in three locations throughout the state and the panel participants and moderators were: Northern Region: Henry J. Mineur, M.D., moderator; Burton L. Eichler, J.D., and William F. Minogue, M.D., panelists; Central Region: Howard D. Slobodien, M.D., moderator; Paul R. Murphy, J.D., and Norval F. Kemp, M.D., panelists; Southern Region: John S. Madara, M.D., moderator; Burton L. Eichler, J.D., and William J. Kane, M.D., panelists.

The general theme of the seminar was that physicians must become a more cohesive unit, particularly as members of the hospital staff, and begin to sacrifice their individuality for the good of the group.

Some of the predictions of what the future holds for New Jersey physicians include: growth in IPAs; greater harassment from the state and federal agencies with proposed legislation and regulations; more group practices; more hospital-based, salaried physicians; growth in multihospital systems; and growth of HMOs.

According to the panelists and many participants, if physicians want to preserve the autonomy which presently they enjoy, they will need to become more active and vocal in hospital privileges and credential committees. It also was suggested that physicians should work with hospital administrators in the establishment of good health care for patients.

Most of the participants felt that the topics presented at these seminars should be of primary concern to physicians but, the lack of concern was evidenced by the small amount of physicians in attendance. One physician summarized the apathy of physicians regarding such matters by relating his question to fellow physicians in England and Canada, "Why did you allow national medicine?" Their answer, "We never thought it would happen here."

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	Gerald H. Rozan, M.D., President-Elect
Salem County	
May 2	Mary T. DiMedio, M.D.
Somerset County	
February 13	Albert M. Doswald, M.D., President
March 20	Albert M. Doswald, M.D., President
	John H. Lifland, M.D.
April 10	Leon S. Gabaeff, M.D., President-Elect
Sussex County	
April 10	Ewald H. Bergmann, M.D.
Union County	
January 16	Frank R. Romano, M.D., Past President
February 13	Frank R. Romano, M.D., Past President
	Mrs. Ethel Stevens, Executive Director
March 20	Mrs. Ethel Stevens, Executive Director
April 10	Frank R. Romano, M.D., Past President
	Mrs. Ethel Stevens, Executive Director
April 29	Frank R. Romano, M.D., Past President
May 2	Frank R. Romano, M.D., Past President
	Mrs. Ethel Stevens, Executive Director

tration in order to continue practicing. The current biennial registration period expired June 30, 1983, and the new biennial registration period runs from July 1, 1983 to June 30, 1985.

In prior years, the biennial registration applications have been mailed out approximately 45 to 60 prior to the expiration of the current registration. Unfortunately, this cannot be done this year because the Board has proposed an increase in the registration fee, and is awaiting formal approval of that proposed increase (the increase will be from $30 every two years to $80 every two years). Therefore, the new biennial registration applications were mailed out the middle of June, and the period for the return of those applications will be extended to July 29, 1983.

For further information, please contact SBME, 28 West State Street, Trenton, NJ 08608.

DRUG HOTLINE

The statewide Drug Hotline (800-225-0196) is a 24-hour, toll-free, confidential telephone service funded by the New Jersey Department of Health, Division of Narcotic and Drug Abuse Control. The hotline is operated by Together, Inc., 7 State Street, Glassboro, NJ 08028.

The Drug Hotline serves people who think they may have a drug problem; families and friends concerned about someone's drug use; professionals needing information; and persons wanting information.

Telephone counselors include trained volunteers and paid staff who are qualified in crisis intervention, listening, and problem solving. They have access to over 10,000 current social services referrals throughout New Jersey.

ATTENDANCE AT BOARD OF TRUSTEES' MEETINGS

Specialty Societies, AMNJ, and Auxiliary—January 1983-May 1983

New Jersey Allergy Society
April 10 — Richard J. Bukosky, M.D., President

New Jersey State Society of Anesthesiologists
March 20 — Stanley Bresticker, M.D.
April 10 — Stanley Bresticker, M.D.
April 29 — Stanley Bresticker, M.D.

New Jersey Dermatological Society
January 16 — Gabriel F. Sciallis, M.D., President-Elect
Albert L. Rosenthal, M.D.
February 13 — Albert L. Rosenthal, M.D.
March 20 — Gabriel F. Sciallis, M.D., President-ELect

New Jersey Chapter, American College of Emergency Physicians
March 20 — Rudolf E. Schwaeble, M.D.
April 10 — Rudolf E. Schwaeble, M.D.

New Jersey Society of Internal Medicine
February 13 — Frank J. Malta, M.D., Past President
March 20 — Frank J. Malta, M.D., Past President
April 10 — Frank J. Malta, M.D., Past President
May 2 — Frank J. Malta, M.D., Past President

New Jersey Association of Medical Specialty Societies
February 13 — Frank J. Malta, M.D., Vice President
March 20 — Stanley Bresticker, M.D., President
Frank J. Malta, M.D., Vice President
April 10 — Stanley Bresticker, M.D., President
Frank J. Malta, M.D., Vice President
April 29 — Stanley Bresticker, M.D., President
May 2 — Frank J. Malta, M.D., Vice President

New Jersey Neurosurgical Society
April 10 — Anthony Chiurco, M.D., President-Elect
May 2 — Lawrence Strenger, M.D.

Obstetrical and Gynecological Society of New Jersey
March 20 — Courtney M. Malcarney, M.D., President-Elect
April 10 — John D. Franzoni, M.D.

Occupational Medicine Association of New Jersey
January 16 — Joseph J. Cillo, M.D., President

New Jersey Academy of Ophthalmology and Otolaryngology
January 16 — Saul M. Tischler, M.D.
February 13 — Vincent B. Pica, M.D.
March 20 — Saul M. Tischler, M.D.

New Jersey Orthopaedic Society
January 16 — Bernard A. Rineberg, M.D., President
April 10 — Bernard A. Rineberg, M.D., President

New Jersey Society of Pathologists
March 20 — William V. Harrer, M.D., President

New Jersey Society of Physical Medicine and Rehabilitation
January 16 — Robert Iskowitz, M.D., President
February 13 — Robert Iskowitz, M.D., President
March 20 — Robert Iskowitz, M.D., President

New Jersey Psychiatric Association
February 13 — John C. Patterson, M.D., President-Elect
March 20 — John C. Patterson, M.D., President-Elect

New Jersey Rheumatism Association
January 16 — William E. Ryan, M.D., Liaison Representative
March 20 — William E. Ryan, M.D., Liaison Representative
April 10 — William E. Ryan, M.D., Liaison Representative

Academy of Medicine of New Jersey
February 13 — Mr. Charles E. Heitzmann, Executive Director

Medical Society of New Jersey Auxiliary
January 16 — Mrs. Linda Hirsch, President
Mrs. Gale Wayman, President-Elect
April 29 — Mrs. Linda Hirsch, President

BLUE CROSS/BLUE SHIELD AND MAJOR MEDICAL

The rising cost of health care protection today makes one review the benefits and services purchased by his/her medical insurance premiums. Cost alone should not be the deciding factor. The coverage and benefits provided by the insurance plan and the service available to enrolled physicians and their families should be taken into consideration.

In some instances, the Blue Cross/Blue Shield and Major Medical Programs sponsored by MSNJ cost more than a direct payment enrollment. However, the Medical Society Programs provide superior coverage and benefits.

It is comforting to know that when travelling throughout the United States or the world, 120 days of fully paid semiprivate hospital care is provided by the Medical Society Program even if the hospital is not a Blue Cross member hospital. The direct payment plan limits payment in such non-Blue Cross member hospitals to only 50 percent of charges not to exceed $100 per day.

The Major Medical Program is very comprehensive. Its low $100 deductible makes it easier to obtain partial reimbursement for those small medical expenses incurred during the year (i.e. prescription drugs, office visits). The low deductible cannot be obtained from the direct payment Major Medical Plan which offers only a $200 or $500 deductible depending upon your health at the time you apply. The Society's Program provides $250,000 per person yearly maximum benefit with no lifetime limit. The direct payment plan has a lifetime maximum limit of $250,000 or only $100,000 depending upon your health when you apply.

There also is the availability of the UCR Blue Shield Series. This assures us that when treated by a fellow physician, the reimbursement for services rendered is more in line with current medical costs. The direct payment plan offers the 750 and 14/20 series payment schedules only.

The Medical Society Programs do not require you to complete a health statement when applying for coverage. You are not penalized because of an existing health condition as you could be as a direct payment subscriber. Full benefits are provided for all covered conditions.

The Plan Administrator of the Medical Society Program is Donald F. Smith and Associates of Prince-

BLUE CROSS/BLUE SHIELD/MAJOR MEDICAL BENEFIT COMPARISON

	MSNJ	Direct Payment
Blue Cross		
Coverage extends to unmarried children.	End of calendar year child attains age 23.	End of calendar year child attains age 19.
120 days paid in full semiprivate care.	All conditions.	Limited to 20 days for mental condition, TB, drug addiction, contagious diseases, and alcoholism.
Out-of-state nonmember hospitals.	120 days fully paid semiprivate care.	50 percent of reasonable charges, maximum of $100 a day.
120 days paid in full semiprivate care.	Per admission.	Per benefit year.
Preexisting conditions.	Covered.	No benefit during first year of coverage.
Blue Shield		
Coverage extended to unmarried children.	End of calendar year child attains age 23.	End of calendar year child attains age 19.
Preexisting conditions.	Covered.	No benefit during first year of coverage.
Major Medical		
Health statement.	Not required.	Required.
Preexisting conditions.	Covered.	No benefit during first year of coverage.
Deductible.	$100 per year, maximum 2 per family.	$200 per year, maximum 2 per family. $500 per year deductible may be assigned because of existing health.
Coinsurance.	80 percent after annual deductible is met.	$200 deductible, 80 percent after annual deductible is met. When covered medical expenses over deductible has been reached reimbursement is 100 percent. $500 deductible, 80 percent after annual deductible is met.
Calendar year maximum.	$250,000 per person	Unspecified.
Lifetime maximum.	Unlimited.	$200 deductible, $250,000 $500 deductible, $100,000
Mental Health Benefits:		
Outpatient mental care coinsurance.	50 percent.	50 percent.
Maximum benefit payment.	$20.00.	$10.00.
Calendar year maximum benefit payment.	$1,000.00.	$500.00.
Lifetime maximum benefit payment.	Unlimited.	$2500 under both deductible plans.
Benefit reduction upon attainment of age 65.	None.	All benefits end.
Coverage extended to unmarried children.	End of calendar year child attains age 23.	End of calendar year child attains age 19. No Major Medical coverage available to child over age 19 who applies for full-time college student enrollment after attainment of age 19.

ton. They have an experienced staff dedicated to providing the best service possible to all program participants. They have a computer terminal linked directly to Blue Cross/Blue Shield which allows them immediate access to the enrollment and claim records. More than 95 percent of all telephone inquiries regarding enrollment and claims are answered immediately. If you have a disagreement with Blue Cross or Blue Shield about a claim payment, their staff will assist you in resolving the disagreement.

To those physicians already enrolled in these programs and to those physicians contemplating enrollment, we appreciate your concern about the medical coverage and cost of Blue Cross/Blue Shield plans available to you. To determine what plan best suits your health insurance needs, we suggest you review the various options carefully. Donald F. Smith and Associates, the Plan Administrator, will be happy to suppy you with any additional information or answer any questions you may have. Call 609-924-8700 or 201-622-6046.

FINI

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THE ANNUAL MEETING

The 217th Annual Meeting of the Medical Society of New Jersey was held at Resorts International Hotel and Casino, Atlantic City, April 29 to May 2, 1983. The following pictures are just a sample of what went on.



The 1983-84 Medical Society of New Jersey Board of Trustees. The bottom row (left to right): Drs. Greifinger; Fullerton; Fioretti; Watson; Costabile; Kovacs; Bernstein; Hirsch; Ramundo; Morrison. The top row (left to right): Drs. Messey; Gingerelli; Kengeter; Crosby; Slobodien; Campo; Formica; Carnes; Cherashore; Pastore.



The 1982-83 Medical Society of New Jersey Board of Trustees. The bottom row (left to right): Drs. Garrison; Fullerton; Fioretti; Kovacs; Slobodien; Formica; Watson; Bernstein; Hirsch; Goracci. The top row (left to right): Drs. Gingerelli; Messey; Kengeter; Campo; Costabile; Robins; Greifinger; Crosby; Carnes; Morrison.



The 191st President and his wife, Dr. and Mrs. Alexander Kovacs at the House of Delegates meeting.



The County Auxiliary Presidents at their working breakfast. Pres. Mrs. Gale Wayman is seventh from the left.



Dr. and Mrs. Karl Franzoni. Dr. Franzoni was the Acting Speaker of the House of Delegates.



Dr. Paul Hirsch (left), Treasurer of MSNJ, and Dr. Howard D. Slobodien, outgoing President.



A Student Association Meeting with Dr. David I. Canavan, Medical Director of the Impaired Physicians Program, MSNJ (third from left).



Peter Lauer, Executive Director of AMPAC (left), and Dr. William E. Ryan, Chairman of JEMPAC, at the JEMPAC Forum on Saturday, April 30, 1983.

Rule 4:21 Proposed Change

In August, 1982, a Committee created by the New Jersey Supreme Court was formulated to evaluate Rule 4:21 (Table 1). The Committee consisted of judges who had served as chairmen of the pretrial panels, plaintiff and defense attorneys with medical malpractice litigation experience, and several physicians. Specifically, the Committee was asked to recommend either retention, modification, or termination of the Rule.

The following are the recommendations of the Committee as they appeared in the March 10, 1983, issue of the *New Jersey Law Journal:*

A. Case Management

The Committee recommends that Rule 4:21 be amended to provide that:

(1) All medical malpractice cases, including those that involve physicians as well as health care institutions and other health care professionals specially be assigned to a judge experienced in hearing malpractice cases. Judges formerly assigned to conduct malpractice panels and those presiding at medical malpractice trials are most suited to this responsibility. The case specially should be assigned as soon as practicable after the first answer is filed.

(2) To the extent feasible, medical malpractice cases should be tried by the judge initially assigned pursuant to paragraph 1.

(3) A mandatory pretrial conference shall be held within one year of the service of the complaint, with an appropriate order to be entered.

B. Voluntary Panel Participation

The Committee recommends that the present medical malpractice panel procedure be available for use by the parties on a voluntary basis.

Participation in a panel hearing shall be only with consent of the plaintiff and defendant physician. All provisions of Rule 4:21 shall apply in those cases where the parties have consented to participate, that is, a unanimous finding shall be admissible at trial.

The Committee recognized that there may be instances where a panel is useful and urges that the option for a panel remain, since the administrative structure already is in place. Extensive use of this voluntary procedure is not anticipated.

C. Pending Case

The Committee recommends that no mandatory panel hearing be held on or after the effective date of the proposed amendments.

To ensure a smooth transition, the Committee urges that the mandatory panel hearings cease to be held as quickly as possible. During the life of this Committee, many attorneys and judges have questioned what the effect of the Committee's recommendation would be on pending cases where panels have been scheduled but not held. Some attorneys have refrained from filing suits in the hope that their cases would not be subject to the mandatory panel procedure. Accordingly, the Committee urges the Supreme Court to speak definitively on the subject to foster uniformity and minimize disruption to the court system. Unanimous findings in those cases where a panel hearing already has been held should be admissible at the trial of the action.

TABLE 1
Rule 4:21

Administered by the Administrative Office of the Courts, Rule 4:21 was created by the Supreme Court and became effective in 1978. Rule 4:21 requires all medical malpractice actions against a physician to be submitted to a pretrial panel consisting of a trial judge, a physician, and an attorney. The purpose of these pretrial panels is to: (1) discourage baseless actions; (2) encourage settlement of claims based on reasonable medical probability; (3) monitor efficiently these cases through the court and; (4) assist in the early disposition of medical malpractice actions.

The Committee's recommendation for modification of Rule 4:21 was based on an analysis of the following concerns: (1) the program relies on volunteers, hence, it is becoming increasingly difficult to obtain qualified medical and legal panelists; (2) parties are prejudiced by delays in scheduling panel hearings; (3) the panel proceeding unduly consumes valuable time of judges who also are assigned other cases for trial; (4) plaintiffs' costs for expert witnesses greatly have escalated; (5) cases which do not settle after the panel hearing are not given preference on the trial calendar and, consequently, are relatively old at the time of trial; and (6) the panels are unfair because: (a) there is no sworn testimony on the record, (b) the opinion of the doctor-panelist, because of his expertise, carries a disproportionate weight in the panel's determination, and (c) it virtually is impossible to overcome the impact on a jury when they are told that an "expert" panel has made a unanimous finding in favor of one of the parties and that this finding is evidence for, but is not binding on the jury.

To assist the Committee on their evaluation, questionnaires were sent to lawyers who had represented a party at a hearing. The Medical Society of New Jersey sent the same questionnaire to physicians who served as panelists as well as those who had been defendants. All judges assigned to conduct medical malpractice panel hearings were asked for their views.

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse who are, respectively, Director of the Department and Director of Special Projects.

TABLE 2
Results of Survey

	Number Asked To Respond	Number Responded
Lawyers	400	200
Physicians	270	140
Judges	26	19

Generally, attorneys who represented the defendants were more supportive of the Rule. The majority of all attorneys agreed that Rule 4:21 appears to be unfair to claimants, appears to be fair to defendants, results in a net loss of judicial time, and makes medical malpractice litigation more costly. The majority of physicians responding to the questionnaire believed that Rule 4:21 is fair to claimants and saves judicial time. A majority of Rule 4:21 judges stated that Rule 4:21 aids efficient disposition, results in a net loss of judicial time, and has made medical malpractice litigation more costly. Most expressed an opinion that Rule 4:21 could be improved. The majority of judges urged individualized case management, with the abolition of the mandatory panel as the best alternative.

Clearly, members of the bench, the bar, and the medical profession support the need for special management of medical malpractice cases. A majority of all of those polled agreed that the benefits of the mandatory panel procedure are outweighed by practical problems that interfere with the stated purpose of expeditious disposition. The majority also agreed that the best feature of Rule 4:21 is its built-in requirement for continuous case monitoring. The provision requiring a mandatory pretrial conference within one year of the service of the complaint has prompted many Rule 4:21 judges to conduct a "management" conference several months prior to pretrial conference. At this case management conference, problems concerning discovery and expert witnesses are resolved, so that at the pretrial conference, the judge is able to go forward with a request for designation of panelists.

Because of the detailed preparation necessitated by the impending panel hearing, attorneys are ready for meaningful settlement discussions prior to the hearing.

Statistical information presented to the Committee from the Administrative Office of the Courts indicated that there was no significant difference in the disposition of a medical malpractice case brought before or after the implementation of Rule 4:21. However, 5 percent more cases have been tried since the implementation of the Rule and the disposition time declined from a period of 2 years and 3 months prior to the Rule, to 1 year and 8 months.

The Committee was cautioned that although these later statistics are indicative that Rule 4:21 is working, a large percentage of cases still are pending that would make any judgment inconclusive.

The Committee report concluded with the statement, "The Committee acknowledges the efforts of the many attorneys and physicians who have volunteered their valuable time to serve as panelists. It has been a worthwhile experiment. The Committee feels it is time to build on the knowledge we have gained and to fashion procedures which hold greater promise for the fair and expeditious processing of medical malpractice cases without adding to the cost of litigation or making excessive demands on the time of trial judges. Special assignment of medical malpractice cases, with an emphasis on continuous monitoring by trial judges will benefit litigants, attorneys, physicians, and the general public."

Editor's Note: The Committee report was accepted by the Supreme Court and the recommendations became effective May 4, 1983.

A RESPONSE TO FREQUENCY OF CLAIMS ASSERTED

A number of factors combine to produce rate development regarding your professional liability insurance coverage. Frequency of claim assertion is a problem that the Medical Inter-Insurance Exchange of New Jersey (MIIENJ) clearly has identified as a major cost factor. A successful solution to frequency has not been forthcoming.

The ratio of claims and suits to insured physicians consistently has been rising at a rate of 5 percent per year. Actuarial projections indicate a higher escalation in the 1983 policy year. Many people believe that the rise in frequency strongly is related to frivolous suits and nuisance claims. MIIENJ has closed 1,642 cases. Indemnity payments were made on 812 of those cases while 830 cases were disposed of without indemnity payments.

In the vast majority of the 830 nonindemnity cases, there was a valid issue regarding the care rendered that required explanation. It was established by MIIENJ staff review that there were few, if any, nuisance or frivolous claims/suits. The allocated loss expenses for these cases totaled $1,638,361. Better physician-patient communication could have prevented most, if not all, of the 830 cases under discussion and thus saved the $1,638,361 in allocated loss expenses.

The following concepts can improve communication. If physicians adhere to the following concepts for improved communications, MIIENJ and other medical professional liability insurers will be able to control the frequency of claim assertion in those instances where there has been no injury attributable to malpractice.

1. Physician hindrance of patient attempts to obtain medical record information increases suspicion and fear. Do not hinder your patient's request for medical record information.

2. Advise your patients where they can secure medical care during your absence. Do not leave your practice unattended.

3. Discuss your fees with your patients prior to rendering services. If circumstances preclude this, direct your efforts to an amicable understanding and adjustment.

4. Patients become upset and angry when kept waiting for appointments. Develop an office schedule to minimize waiting time.

5. Unexplained complications generate a significant amount of litigation. When complications occur, discuss them with the patient as soon as possible, and institute prompt corrective therapy.

6. There is a greater frequency of suit in group practices as opposed to individual practices. Conduct case management conferences with your associates and be certain that someone is in close contact with the patient.

7. People do not sue people they like and respect. Good patient rapport, i.e. common decency and courtesy, is necessary to your practice.

These concepts are the basis of sound personal relationships. Physician conduct and demeanor are as important to patients as a physician's technical skills. Cultivation of sound relationships will control the frequency of claims assertion.



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There is a road.

Many cancer patients need transportation to and from treatments. That's why the American Cancer Society has formed groups of volunteers across the United States who give a few hours of their time each month to drive them. The road to recovery can be a long and difficult one, but it can be that much easier when there are friends who can help along the way.



American Cancer Society

This space contributed as a public service.

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request

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Pfizer LABORATORIES DIVISION
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"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

*Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page*

MSNJ's 217th Annual Meeting

The 217th Annual Meeting of the Medical Society of New Jersey, at Resorts International in Atlantic City, has come and gone—with some memorable events.

We have a new President (Alexander D. Kovacs, M.D.), a new President-Elect (Frank Y. Watson, M.D.), and a new Chairman of the Board (Douglas M. Costabile, M.D.). The Secretary (Arthur Bernstein, M.D.) and the Treasurer (Paul J. Hirsch, M.D.) were reelected.

A small ripple was presaged by a fortune cookie (message: "Why settle for an autopsy when rebirth is possible?") placed at each delegate's place by a candidate for President-Elect, Frank Primich, M.D. Dr. Primich was nominated from the floor, but lost to the official candidate, Dr. Watson. This was the first instance in recent memory of a nomination from the floor.

A significant debate on the issue, "direct candidacy for elective office," took place in the Reference Committee on Constitution and Bylaws. The Reference Committee felt that there were legitimate reasons to look into the merits of a revised nomination and election procedure and the House adopted the following resolution:

Resolved, that the Board of Trustees of the Medical Society of New Jersey seeks advice concerning alternate methods of carrying out the nomination and election procedure for officers and trustees. The Board of Trustees shall report its findings and conclusions to the 1984 House of Delegates.

A superb résumé of the American Medical Association's program and activities was delivered with great spirit by a former New Jerseyan, Joseph F. Boyle, M.D., who is a strong candidate for the office of AMA President, and currently is chairman of the AMA Board of Trustees. There should have been no doubt in the minds of the delegates as to the vigor of the AMA and its leadership, nor any question as to the wisdom of membership in the national organization.

JEMPAC's spokesman, William E. Ryan, M.D., chairman of the state political action organization, made a forceful statement on political and legal issues that directly impact on organized medicine and on individual physicians. He emphasized the poor contribution record of physicians to political action committees in the 1981 legislative elections. The largest PAC contributors were dentists, followed in order by business and industry associations, lawyers, auto workers, communication workers (including state employees' union), realtors, and builders.

In a similar vein, the House of Delegates acknowledged with pleasure the presentation of an unrestricted three-year grant to the Board of Trustees of the Medical Society of New Jersey by the New Jersey Orthopaedic Society, as follows:

Resolved, that the House of Delegates of the Medical Society of New Jersey extends to the New Jersey Orthopaedic Society its appreciation and continued cooperation on issues affecting the practice of medicine in New Jersey.

This is an example of "putting your money where your mouth is" and it shows how a specialty organization can contribute to the broad group in addition to its own limited membership.

A great deal of controversy has arisen in relation to the proposed revisions of the medical staff standards in the *Accreditation Manual for Hospitals* by the Joint Commission on Accreditation of Hospitals. Although the Board of Trustees of MSNJ already has informed the Joint Commission on Accreditation of Hospitals of its opposition to the change in name and composition of the hospital medical staff, the House of Delegates, in order to assure debate on the subject at the June meeting of the AMA, passed the following resolution:

Resolved, that the Medical Society of New Jersey instructs its AMA Delegation to oppose strongly the implementation of the proposed changes by the Joint Commission on Accreditation of Hospitals because they would lead to a decrease in the quality of care for future hospital patients.

Two related items came before the House and dealt with potential adverse influences of professional review organizations (PRO) and the diagnosis related groups (DRG) method of hospital reimbursement in patient care. In the former, Reference Committee "C" proposed and the House approved the following:

Resolved, that the Board of Trustees of the Medical Society of New Jersey, monitors the development of PRO under the current federal and state regulations and establishes an ad hoc committee to act as a liaison with the appropriate PRO, in order to prevent unreasonable interference with good medical practice, and insure physician involvement in the review process; and be it further

Resolved, that MSNJ establish a central reporting system to document cases where PRO activities adversely affect patient care.

The DRG relationship to posthospital discharge morbidity and mortality was raised by Delegate George Triebenbacher, M.D., of Ocean County. Dr. Triebenbacher, an assistant county medical examiner, indicated a concern that undue pressures on attending physicians were causing early death or relapse and rehospitalization. Although he had no specific data, Dr. Triebenbacher's comments made headlines in *The New York Times* and stimulated Vincent Maressa, Executive Director of MSNJ, and Dr. Richard Goldstein, the State's Commissioner of Health, to develop a documentation process for such alleged instances.

Finally, a bittersweet event took place at the outset of the meeting. Our erstwhile Speaker of the House, Henry J. Mineur, M.D., of Cranford, was forced to withdraw from conducting the business of the House because of his wife's serious illness. The Vice-Speaker, Karl Franzoni, M.D., of Trenton, who regularly has waited in the wings, was tapped for the job at the last moment. Dr. Franzoni, with the assistance of James E. George, M.D., J.D., did a highly creditable job and gained the plaudits of all present. A.K.

The Rhuses Are Coming!

As certain as little green apples, the lengthening days and warm sun of summer bring the lure of outdoor living. We rush to enjoy the renaissance months, shedding the old season's confining clothes, baring skin, and getting close to nature. While surely the formula for contentment, the same recipe also leads to troubles most gladly would avoid. Summer is the time of testing for our skin. It will be assaulted by ultraviolet radiation, biting creatures, and, importantly, the lurking members of the *Rhus* family of plants. Poison ivy, poison oak, and poison sumac will cause more mischief during the summer than all other causes of allergic contact dermatitis combined.

Rhus plants contain an oleoresin with a potent allergen, pentadecacatechol, which quickly penetrates skin and triggers the cell-mediated defenses of susceptible individuals. Although prompt washing with soap and water will remove the oleoresin, most people are unaware of the actual contact, or are far from the means to effect a quick lavage. Inevitably, within a day or two, exposed areas of skin will erupt with an intensely itchy, red raised rash, usually with small or confluent blisters. Linear streaks attest to the paint job done by the brushing foliage. The dermatic face usually is diffusely red and swollen, with the victim resembling the battered loser of a 15-round heavyweight boxing match.

Several aspects of the distribution and evolution of the eruption commonly confuse the patients or their families. The protesting gentleman, for instance, with the red, swollen, itchy penis knows he has not exposed himself in the woods. He simply has not realized that the heavy, well-protected, unreactive palmar skin on his hands, has transferred the oleoresin to the other, more susceptible, thin-skinned organ when he urinated. The distraught mother who sees the dermatitis spring up first on one part of the body, then another, on successive days, feels certain her child is a public health menace and is spreading the condition from the fluid-filled blisters. She needs reassurance that the liquid is serum, not additional allergenic juices; that different body sites react at varying rates; and that a thorough washing of the clothing worn at the time of contact, and the dirty fingernails, may be needed to complete removal of the oleoresin.

What is to be done for the suffering patient after the dermatitis appears? The acute *Rhus* rash is the archetype of "wet dermatitis" which must be made "dry." Calamine lotion has been used for this purpose for many years and undoubtedly will be used for many more. It has disadvantages when dealing with widespread and very symptomatic problems since it effectively limits the topical therapy options. The pink residue of repeated applications precludes the use of other, more effective antiinflammatory agents. A suitable alternative is to apply compresses to the affected areas with diluted Burow's solution, for 20 minutes, four times daily, and for no more than three days. After 12 treatments, the skin may become overly desiccated, flaked, and cracked. Since it takes two or three weeks for the condition to run its course, a topically applied, moderate potency, fluorinated corticosteroid cream can be prescribed, both for immediate use after each Burow's solution compress, and for the remaining time till complete resolution. If the itching is interfering with sleep, oral hydroxyzine can be taken at bedtime.

For the very widespread and severe dermatitis, particularly when the face or other vital parts are involved with the eruption, stronger medicine may be needed. Full-dose corticosteroids, given in a gradually declining dosage over a two-week period, is appropriate. Short-burst therapy, particularly the variety using the prepackaged five-day supply, is to be avoided. Rebound episodes of dermatitis occur when the patient is vulnerable, and protected by neither exogenous nor sufficient endogenous adrenocorticoids. Such explosions are apt to be even more violent than the original episode.

Doubtless, it would be better to avoid the noxious *Rhus* plants altogether. "Leaves of three, let it be!" is easy to remember, but difficult to translate into practical purpose. Meanwhile, cover up as much as possible when scouting sylvan shades, and, good luck!

Christopher M. Papa, M.D.

AMNJ: Tradition and Challenge*

The Academy of Medicine of New Jersey (AMNJ), the educational arm of MSNJ, is the primary organization for physician education in our state, and I am proud to have the opportunity to serve as its President.

The Academy tradition of educational excellence has served the New Jersey medical community for more than 70 years. During the past decade, however, the Academy has changed greatly. The Medical Society of New Jersey assigned the Academy the task of evaluating and approving educational programs in our state for AMA Category I credits. This approval process, which assures excellence in continuing medical education, quite properly utilizes much of the Academy's resources. In addition, at about the same time, the Academy of Medicine began to assist medical specialty societies in New Jersey by providing administrative and secretarial services. We now provide such services for 26 societies.

It may seem that these important functions have become our main tasks. I wish to assure you that while evaluating educational programs developed by others and providing administrative services for other groups, the Academy of Medicine will not lose sight of its primary and most important function: the development and presentation of educational and informational programs that meet the needs of its members. The AMNJ Board of Trustees has approved the hiring of a full-time professional who will be charged with the development of educational programs. A search committee headed by the new chairman of the education committee,

*Presented at the AMNJ Annual Awards Dinner, May 25, 1983.

Dr. Alfred Alessi, will identify the best qualified individual for this position. The education committee will be charged with giving direction to the Academy, indeed, with changing the direction of the Academy, if necessary, to provide for educational needs in the future.

No longer will a few of us sit at a committee meeting and decide the educational needs of others. The Academy must have a formal and ongoing program to identify the needs and wants of our members, using such strategies as mail surveys, audits, malpractice data, recommendations of educators, specialty societies, and practicing physicians, and perhaps a hot-line telephone.

No longer should the Academy of Medicine be content to primarily approve of, or to merely assist in, the development of programs or symposia. We must identify the needs for such programs, seek the best faculty and the best format, produce the program, and present it in a convenient manner.

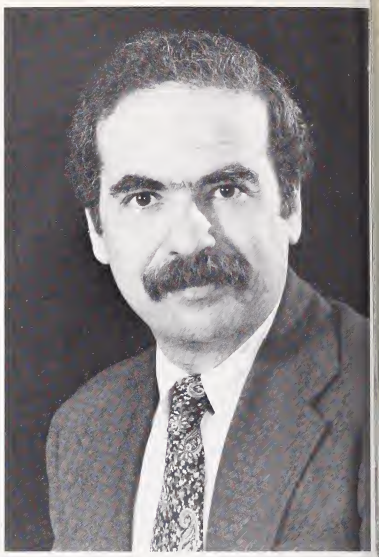
No longer can we rely on lectures and symposia for our educational programs. The time has passed when education consisted only of a parade of speakers, before an audience of listeners. We must utilize new and innovative educational processes such as: telephone conferences, videotaped instruction, mini-residencies, computerized bibliographies and other computer programs, and hands-on instruction.

No longer can we ignore the public demand and the proper public need for education in matters concerning medicine. I believe that we should fill this need and that the Academy of Medicine should begin to address the problem of public medical education.

No longer can we be content with the size of our membership, though it is growing. More New Jersey physicians do not belong to the Academy than do. Our membership committee has done a wonderful job in recent years and I am confident that our new chairman, Dr. Benjamin Rush, will provide the leadership necessary to further our growth.

For more than seven decades, the Academy of Medicine has maintained a tradition of quality education, responding to the wants and needs of the practicing physician.

We only can continue this tradition by successfully meeting the challenges which are upon us, the challenge to provide better educational programs, the challenge to use new and innovative techniques in our educational processes, the challenge to continue into the future the traditions of our past.



Paul J. Hirsch, M.D.

All members of the Medical Society of New Jersey are urged to join this vital organization which is doing so much for individual physicians and organized medicine.

Paul J. Hirsch, M.D.

JEMPAC Report—A Call To Arms

Two centuries ago, the noted British statesman, Edmund Burke remarked, "All that is necessary for the triumph of evil is for good men to do nothing." I believe we are good men, but to counteract the success of political evil we need to do something substantial in our behalf. Unfortunately, as a group we have not been doing an effective job.

In the near future, if the New Jersey Legislature has its way, you will see your practice eroded significantly and your fees reduced arbitrarily, and you will be dancing to some new and harsh governmental tunes.

There is a virtual plethora of bills being considered by both the New Jersey Assembly and Senate to create new boards for paraprofessionals that will expand their prerogatives of diagnosis and treatment. The paraprofessionals want to accomplish, by legislative fiat, what it took years to accomplish by virtue of training and licensure. Both houses of the legislature also are considering major revisions of the no-fault insurance law with the establishment of a cost control board and the adoption of commissioner-imposed fee schedules.

Let us consider some specific legislation. Assembly bill 785 by Markert provides that "hospitals which have reduced or suspended physician privileges must report the same to the State Board of Medical Examiners. Additionally, insurance carriers must report to the Board of Medical Examiners any medical malpractice awards or settlements which exceed $25,000." What will the Board of Medical Examiners do with this information? Will the press have a field day? At the minimum, this is more harassment for physicians. This bill already has gone through both houses of the legislature and

s on the Governor's desk. (Notice that the bill is not uggesting that other professionals be treated in a similar nanner.)

We recently have been challenged seriously by physio- herapists. Twin bills by Doria in the Assembly and by DeFrancisco in the Senate were introduced to authorize the levelopment of separate boards of practice for physio- herapists to allow patients to come directly to them without he prescription or the direction of a physician. These were rime features of the original bill. As we recognize, many nedical and surgical problems will be missed should the patient go directly to a physiotherapist without diagnostic evaluation. MSNJ responded. Our members, particularly from Union County, and physiatrists teamed with Joe Katz, our lobbyist, and persuaded the authors of this legislation that physician direction indeed was warranted. At the pres- ent time, this language is back in the bill.

Assembly bill 2149 by Otlowski provides that optometrists may use and prescribe drugs for topical application to the anterior segment of the eye. This presumes that optometrists now will be able to treat certain forms of eye disease. Current law limits the practice of optometry to "the examination of the human eye for the purposes of measuring the powers of vision and adopting lenses and prisms for the aid thereof." This bill would allow the optometrist to treat "red eye." This may be iritis, conjunctivitis, and cornea ulcers that, of course, may be well beyond the training of an optometrist.

Dr. Howard D. Slobodien, in his letter to the legislature, points out that this is not merely a dispute between "a few hundred optometrists and a few hundred opthalmologists. A-2149 represents a basic encroachment into the practice of medicine by practitioners who are in no way qualified to assume these responsibilities."

Storm clouds are gathering on yet another issue which may overshadow any of these legislative efforts. There are approx- imately six bills being introduced on the subject of no-fault insurance. These are particularly dangerous for the society since the bills create a commissioner of insurance-mandated fee schedule and the bills suggest a cost control board made up of a predominance of nonphysicians.

Physicians of this state have participated poorly when it has come to contributing money to political causes. For example, in the 1981 legislative campaign, automobile work- ers contributed $123,000; lawyers contributed $105,000; the Dental Pac contributed $104,000; realtors contributed $78,000; and car dealers contributed $62,000. If one runs a finger down the list of PAC contributors, finally one comes to physicians, who contributed $18,000. We are putting up about 12 percent of labor and about one-sixth as much as our colleagues, the dentists. Certainly, physicians outnumber dentists, and on balance have more at stake politically, and yet, we have been shamed by their political acumen.

I spoke to John Torok, the lobbyist for the State Dental Society, who indicated that there are three dental legislators and that they have approximately $250,000 available for political activity. I am not suggesting this will be the case, but should we ever have to go eyeball to eyeball with dentists, it takes very little imagination to know how things will come out.

We need your dollars for political activity. Your monies are contributed for candidate support. The Medical Society of New Jersey is very helpful. It provides basic support services and money for political education. The Medical Society of New Jersey, however, is prohibited by law from providing monies for candidate support, but JEMPAC does make such contributions.

In conclusion, I trust that Edmund Burke did not have a premonition of us. As practicing physicians and as MSNJ members, we have serious problems that lay immediately ahead of us. The most imminent problems appear to involve bills in our New Jersey Legislature. JEMPAC can be of major help, but we need your membership and we need your membership contributions to be effective. The monies you give enable us to support political candidates favorable to our point of view. Please help us to support this interest in your behalf.

Let me close with the words of Peter Lauer, Executive Director of AMPAC, "The politicians feel free to practice medicine—physicians should feel free to practice politics."

William E. Ryan, M.D.

Exclusive Contracts

An increasing number of physicians are entering into contractual arrangements with hospitals to furnish medical services. The most common type of contract is exclusive in nature. This allows the particular practitioner or group of practitioners the right to provide specialty medical services in the hospital and excludes other physicians in the same specialty from access to the institution.

Exclusive contracts are desirable from the hospital's perspective for a number of reasons. The reasons most often advanced by the hospital governing board and management are:

1) Improvement and consistency in the quality of care.
2) Cost containment.
3) Enhancement of teaching programs.
4) Efficiency in hospital administration and management.

The courts generally have upheld the right of hospital governing boards to enter such arrangements and to enforce them under the theory that it places the hospital in the best position to serve the community. While these contracts have been upheld, frequently they have come under legal attack.

The most prevalent legal theory advanced by physicians who are attempting to break exclusive arrangements is restraint of trade under state law. This argument generally has failed in New Jersey because such cases are determined under the "rule of reason." This means that the factual complexes are reviewed carefully and only those contracts or arrangements that unreasonably restrain competition are prohibited. Exclusive contracts, therefore, are not a per se restraint of trade or per se unreasonable.

The increasing supply of physicians and the projected manpower surplus estimated for the end of this decade may create circumstances which will alter judicial approval of these contracts. Two current cases attacking the concept of exclusive anesthesia contracts are of vital interest to hospital governing boards and their medical staffs. Belmar et al. *v* Cipolla et al., Supreme Court of New Jersey, Docket No. 20, 472, has been certified for hearing by our state Supreme Court. The chancery division of the Superior Court determined that an exclusive contract existed, that exclusive contracts are not unlawful, and that unless the parties act arbitrarily or grossly against the public interest the courts will not intervene (July 7, 1981). On October 20, 1982, the appellate division of the Superior Court unanimously affirmed the opinion of the trial court. The granting of certification by the State Supreme Court is an indication by the Court that this issue is of such magnitude that a determination by our highest court is in order.

The federal courts routinely have avoided consideration of exclusive contracts under federal antitrust law. This probably has occurred because the Federal Trade Commission and the United States Justice Department have maintained that there is no "per se" violation and that under the "rule of reason" the matter is best settled under state laws. A recent Louisiana case, however, has managed to find itself before the United States Supreme Court.

In Hyde *v* Jefferson Parish Hospital et al., the Federal District Court found the exclusive contract to be lawful stating that there was no "per se" violation. The Court ordered the suit dismissed. That decision was appealed. The Fifth Circuit Court of Appeals held that a "per se" violation existed because of a "tying arrangement." A "tying arrangement" is considered a "per se" violation. It means that in order to purchase a certain product the consumer is required by the vendor to purchase another product. In this instance, the "tying" was found to exist between the services of the surgeons and those of the anesthesiologists. Neither the surgeons nor patients could select another anesthesiologist. Under these circumstances, it was determined that the hospital dominated the market with the anesthesiologists, and the contract was declared a "per se" violation on September 20, 1982. The United States Supreme Court has granted certification because of the public interest in this issue and the necessity to settle federal law since other circuit courts of appeal have reached different conclusions in similar cases.

CONCLUSION

Hospital governing boards and their medical staffs should conduct a deliberative review of exclusive contracts and their impact on the quality of patient care, hospital efficiency, and physician rights. This review should encompass not only administrative and quality assurance parameters, but also socio-economic and legal factors and trends. V.A.M.

*The material for this column is coedited by Arthur Krosnick, M.D., Editor of *The Journal;* Vincent A. Maressa, Executive Director, MSNJ; and James E. George, M.D., J.D., Director of the Department of Professional Liability.

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THE

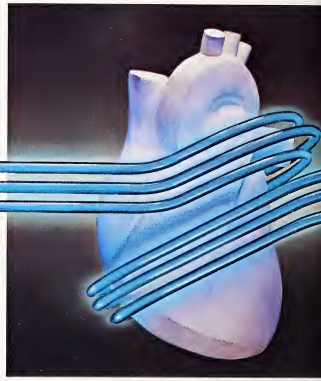
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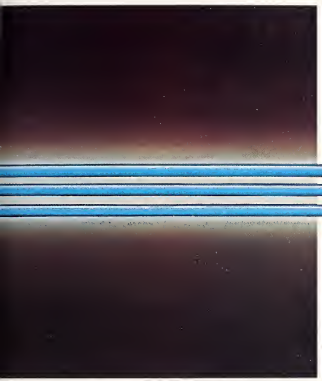
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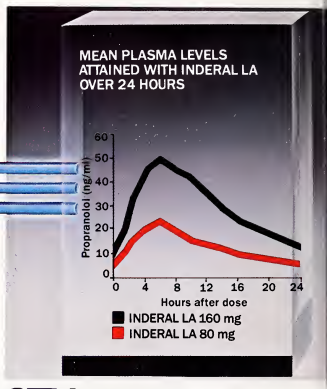
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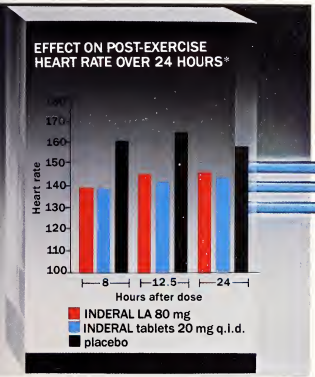
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Compatible with other conventional antianginal therapies

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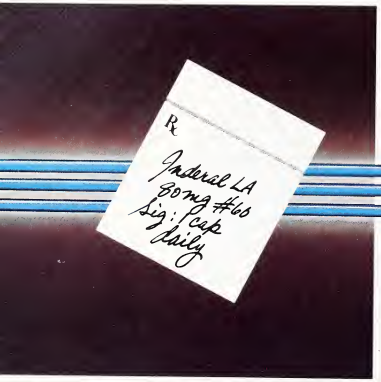
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ONCE-DAILY® (PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg 120 mg 160 mg

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride
(80 mg, 120 mg, 160 mg Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of membrane action in relation to therapeutic effects is not established.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta-receptor blockade can be expected to reduce the heart's workload, or pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely impaired myocardium, adequate ventricular function may be maintained only by sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction time. Finally, results in chronic bronchopulmonary disease may be antiadrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE, Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for patients who have dyspnea or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated left ventricular pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree AV block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, they can be administered with close follow-up to patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely. If INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) – PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists, and its effects can be reversed by administration of such agents, e.g. dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in rats and mice, employing doses up to 150 mg/kg/day there were no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Teratogenic Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular System: Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION – *Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS – *Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the values and limits of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE – *Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS – 80-160 mg INDERAL LA once daily.

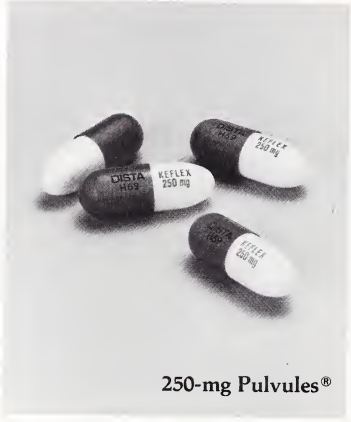
PEDIATRIC DOSAGE.

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

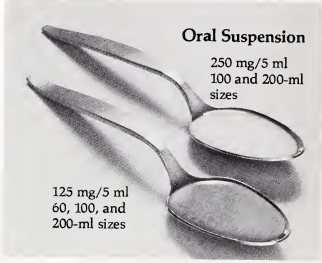
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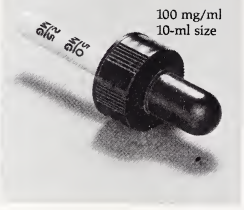


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Guidelines for Immunization During Pregnancy

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Any physician caring for women in the reproductive age group will face the issue of immunization during pregnancy. This paper outlines the types of vaccines currently available and attempts to provide specific guidelines for their use in pregnancy, with special attention to the safety of the fetus.

Immunization during pregnancy always has been controversial. It is ideal to ensure that women are immunized adequately before they become pregnant, but anyone administering a vaccine to a woman of childbearing age should inquire as to the possibility of pregnancy.

Vaccination of pregnant women should not be undertaken as part of a program to protect a community. Care should be taken to determine a pregnant woman's susceptibility to a given disease before a vaccine is administered. The patient's risk of exposure to a given disease also should be considered, since reduction of exposure may make it feasible to avoid vaccination altogether. If it has been determined that exposure is likely or unavoidable, the hazards of the disease must be balanced against the potential harmful effects of vaccination. In assessing these risks, the physician must be aware of any special complications which pregnancy can impose on the disease process.

TYPES OF VACCINES

Vaccines are of four general types: live vaccines, killed vaccines, toxoids, and immune serum globulin preparations. Live-virus vaccines are strains of virus selected for their reduced virulence, whether this be a selected property of the virus or produced by serial passages of the wild virus in tissue culture (attenuation). Killed vaccines contain heat-inactivated or chemically inactivated microorganisms. Toxoids are bacterial exotoxins that have been altered chemically, usually by the addition of formaldehyde, so that they are nontoxic but retain their antigenic properties. Immune serum globulins are protein fractions of human plasma that can produce transient, passive antibody protection.

RUBELLA

Rubella vaccine probably has been the most thoroughly studied with regard to possible deleterious effects on the fetus. The vaccine consists of attenuated, live rubella virus that immunizes by causing infection. Rubella vaccine, therefore, is strictly contraindicated during pregnancy because of the theoretical risk of damage to the fetus. It should be noted, however, that not a single case of congenital rubella syndrome to date has been attributed to rubella vaccination during pregnancy.

Since 1969, the Centers for Disease Control (CDC) has kept a register of women inadvertently given rubella vaccine within three months before or after conception. Among 364 live births of "exposed" infants, none has suffered recognized defects attributable to the vaccine viruses.[1]

In a susceptible woman, rubella vaccine virus can cross the placenta and infect the fetus, for it has been isolated from fetal tissue obtained at therapeutic abortion. Hayden et al. report four clinically normal infants with serologic evidence of congenital rubella infection following maternal vaccination in early pregnancy.[2] The CDC reports 2 of 84 infants of known susceptibles who were vaccinated around the time of conception to have serologic evidence of rubella infection, making even the theoretical risk of damage to the fetus less than 5 percent.[3] It would be difficult on the basis of these findings to recommend routine interruption of pregnancy

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when there has been inadvertent vaccination of a susceptible female around the time of conception. Peters and Dowsett condemn such terminations when they are used as a legally defensive measure on the part of the gynecologist.[4] They suggest that women of childbearing age be vaccinated only when there is laboratory evidence of susceptibility; further, they suggest a long-acting, injectable contraceptive in such cases. The CDC currently recommends that rubella vaccine be administered only after pregnancy has been ruled out and only if the patient is willing to avoid pregnancy for the next three months. In the event that pregnancy does occur, no decision for a termination should be made unless there is at least serologic evidence of an antibody response in the female.

An important point to keep in mind is that most of the current data relates to vaccine strains HPV-77 and Cendehill, which no longer are in use. Since the only strain now available (RA 27/3) is a less attenuated strain, studies to assess the teratogenic potential of the RA 27/3 vaccine are needed.[5]

Plotkin states that at least 12 seronegative pregnant women vaccinated with RA 27/3 have yielded products of conception free of virus.[6] Between 1974 and 1977, during prelicense field trials of RA 27/3 live attenuated rubella vaccine, seven vaccinated women were found to be 3 to 8 weeks pregnant at the time of immunization; all seven pregnancies were terminated at 12 to 20 weeks gestation.[7] Fetal tissues failed to reveal infectious virus or fluorescent virual antigen and there was no fetal rubella specific IgM response in the serum. There was no evidence of accelerated development of lymphoid tissue. Preliminary data on the RA 27/3 strain, therefore, is optimistic.

OTHER LIVE VACCINES

Although mumps virus can infect the placenta and fetus, there is no good evidence that it causes congenital malformations in humans. Mumps vaccine virus also has been shown to infect the placenta, but the virus has not been isolated from the fetal tissues from susceptible women who were vaccinated and underwent elective abortions. Because of theoretical risk of fetal damage, however, mumps vaccine also is contraindicated during pregnancy.[8]

Because natural measles infection may cause spontaneous abortion, premature labor, or, possibly, congenital malformations, administration of live measles vaccine is contraindicated during pregnancy.[9] Passive protection is indicated, however, for susceptible pregnant patients exposed to measles infection.

Polio virus has been implicated in first trimester abortions as well as anoxic fetal damage.[3] Live oral polio vaccine has been given to large numbers of pregnant women, however, and there is no evidence that it causes fetal damage or abortions.[9] On the general principle that live virus vaccines are best avoided during pregnancy, the inactivated (Salk) vaccine usually is advised if immunization is necessary during early pregnancy.[10] Because poliomyelitis has been reported to produce paralysis more frequently during pregnancy, immunization is indicated when the risk of exposure is high (local outbreak or travel to countries outside of Europe, North America, or Australia).

Yellow fever still is endemic in tropical parts of Africa and South America. Although the vaccine apparently is harmless to pregnant women and the fetus, avoidance of exposure is preferred to vaccination. A pregnant woman who must travel to an endemic area at least should be encouraged to postpone her vaccination and trip until after the first trimester. If a woman is exposed to risk of yellow fever infection, the hazards of the disease far outweigh the theoretical hazards of immunization and vaccination is not contraindicated at any stage of pregnancy.

Although mortality from smallpox is increased to 90 percent during pregnancy, smallpox has been eradicated and the World Health Organization recommends vaccination against smallpox only for those working with the virus in the laboratory. An international certificate of vaccination no longer should be required of any traveler. The vaccine had been hazardous for the fetus, with fetal vaccinia often leading to abortion or perinatal death.

"The CDC currently recommends that rubella vaccine be administered only after pregnancy has been ruled out and only if the patient is willing to avoid pregnancy for the next three months."

Because of the near 100 percent fatality associated with rabies, pregnancy is not a contraindication to treatment if postexposure vaccination is needed or to preexposure use if the likelihood of exposure is great. A new rabies vaccine (HDCV) prepared from virus propagated in cell cultures was licensed in June, 1980, and gradually is replacing the duck embryo-grown, inactivated preparation (DEV). Preexposure immunization is recommended for veterinarians, laboratory workers, and persons living in or traveling to areas that have a high prevalence of rabies. The United States recommendation is for three injections of 1 ml each given on days 0, 7, and 21 or 28. The method of choice for postexposure immunization includes human rabies immune globulin on day 0 and a series of five doses of HDCV given on days 0, 3, 7, 14, and 28. DEV and horse antiserum to rabies virus may be used if the preferred products are unavailable.[11]

INFLUENZA

Influenza infection was found to increase significantly maternal mortality both in the pandemics of 1918 to 1919 and 1957 to 1958. A few studies have pointed to increases in congenital malformations and childhood leukemia among children born to women who had influenza during pregnancy, but the majority of evidence is nonsupportive. Influenza also has been implicated in increased rates of abortion, prematurity, and low birth weight.[9]

Influenza vaccine usually is a mixture of the most recent inactivated strains of influenza viruses A and B. Influenza vaccination of pregnant women does not appear to be associated with any increased risks but should be reserved for those pregnant women with underlying high-risk conditions. It also is reasonable to avoid giving it during the first trimester.[12]

After the decision to implement a mass immunization program with A/New Jersey/8/76 influenza vaccine in 1976, a prospective study was designed to evaluate the effect of immunization for swine influenza vaccine on pregnant women. Because the program was terminated prematurely in February, 1977, by the occurrence of cases of Guillain-Barré disease, however, real conclusions as to the effect of

the vaccine on pregnancy outcome could not be made. Among the 189 pregnant women who did receive the vaccine, there was no association with maternal, perinatal, or infant complications as compared with a control group of 517. Teratogenicity was not demonstrated.[13]

KILLED BACTERIAL VACCINES

Cholera vaccine is of questionable value and rarely should be given to a pregnant woman since international certificates of vaccination no longer are required. If it is given to a pregnant woman, the intradermal route should be used to minimize the risk of reactions.

Meningococcal meningitis continues to occur in epidemic proportions in populations scattered throughout the world. Groups A and C meningococcal polysaccharide vaccine has proved safe and effective in general, but there had been some concern about its advisability for pregnant women due to its production of immune tolerance in infant mice. A recent CDC study, conducted during a large Brazilian epidemic, showed that the vaccine does not produce immune tolerance in human infants.[14]

The FDA recently licensed a 14-valent vaccine, polyvalent pneumococcal vaccine (Pneumovax®) which should protect against 80 percent of *Streptococcus pneumoniae* infections.[15] There is no specific information on the safety of pneumococcal vaccine administered during pregnancy but, theoretically, it should not be harmful.

TOXOIDS

In the event that a pregnant woman at risk of contact with diphtheria is in doubt whether she has been immunized, the Schick test should be used. A Schick-positive (nonimmune) woman should be given a course of low-dose absorbed toxoid, preferably adult Td.[3,9] Passive immunization with antitoxin also might be considered.

Tetanus is not a condition that is likely to complicate pregnancy, but because of its severe morbidity and mortality, there should be no hesitation to immunize any pregnant patient who presents with even the slightest risk. If the patient has had no booster within the past 10 years, a single dose booster is administered. If there is no history of a primary series, three doses at one- to two-month intervals are given.[3] It is recommended that plain formol toxoid rather than aluminum-adsorbed toxoid be used for adults, especially for booster doses, in order to avoid local reactions.[9]

In underdeveloped countries where there is a high incidence of neonatal tetanus (60 percent mortality), primary immunization or a booster dose is suggested so that passive transfer of antibody can occur from mother to fetus. A recent Indian study has shown that single dose immunization with large amounts of tetanus toxoid is a safe, effective means of immunizing pregnant women.[16]

PASSIVE IMMUNIZATION

Indications for using immune serum globulins are the same for pregnant and nonpregnant women. Although they are not to be used indiscriminately, immune serum globulins pose no known threat to the pregnant woman or her fetus.

Immune serum (gamma) globulin usually will protect the pregnant patient from measles if given within 48 hours after exposure. On the other hand, pooled gamma globulin has not been shown to prevent infection after exposure to rubella or mumps.

Immune serum globulin preparations also are available for women exposed to or anticipating exposure to tetanus, rabies, hepatitis A, or hepatitis B. A dose of 500 mg of normal immunoglobulin confers a high degree of protection against hepatitis A for six months.[9] Any pregnant woman who is an institutional or household contact of a hepatitis patient, or who is traveling to an area where there is a high incidence of the disease, should be given immunoglobulin. Hepatitis B immunoglobulin can be made only from those few patients who manufacture high-titer antibodies to the surface antigen of the virus. Hepatitis B immunoglobulin in a dose of 500 mg is given to the spouses of infected patients (not symptomless carriers) as soon as the diagnosis is made. A similar dose is given a month later. This should protect a pregnant woman against the high risk of infection from her husband.[9]

"If a woman is exposed to risk of yellow fever infection, the hazards of the disease far outweigh the theoretical hazards of the immunization and vaccination is not contraindicated at any stage of pregnancy."

Human antichickenpox immunoglobulin (zoster immune globulin, ZIG) is used to prevent chickenpox in pregnant women, although its efficacy in doing so recently has been challenged.[17] Since ZIG may moderate symptoms of chickenpox, however, it should continue to be given to pregnant women who are at increased risk of contracting the disease.[17]

Vaccinial immunoglobulin, once administered to pregnant women at the same time as smallpox vaccine, no longer is available.

SUMMARY

When the hazards of a disease for a pregnant patient or her fetus outweigh the potential harmful effects of vaccination, immunization becomes necessary.

Although rubella vaccine strictly is contraindicated during pregnancy, congenital rubella syndrome has not been reported to date in association with the vaccine. For this reason, interruption of pregnancy when there has been inadvertent vaccination is not recommended. Other live vaccines, such as mumps, measles, and live oral poliovaccine are contraindicated on theoretical grounds. The inactivated (Salk) vaccine is recommended whenever the risk of exposure to poliomyelitis is high.

Yellow fever vaccine has not been shown to be harmful to the pregnant woman or her fetus, but, nevertheless, is recommended only when exposure to the disease cannot be avoided. Smallpox vaccine has been hazardous to the unborn; fortunately, the eradication of this disease has made the issue of immunization a moot point.

Due to the near 100 percent fatality associated with rabies, the guidelines for both pre- and postexposure vaccination are the same as for the nonpregnant patient.

Influenza vaccine has not been associated with maternal or fetal complications, but should be reserved for pregnant patients with underlying high-risk conditions, and avoided during the first trimester.

Cholera vaccines are of questionable value and should be given intradermally, if at all. Studies on the new, theoretically harmless pneumoccocal vaccine (Pneumovax®) currently are underway.

Tetanus prophylaxis is the same for pregnant and nonpregnant patients, as are the indications for using immune serum globulins.

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CRITERIA TO WARRANT COMPUTERIZATION

The District of Columbia Medical Society published the following self-diagnostic questions after a careful investigation of the issues pertaining to medical office computerization. A positive response to any one of the first four questions or a total of seven YES answers constitutes cost justification for an immediate move to computerization:

1. Do you have a full-time employee spending more than 50% of their time processing third party claims and patient bills?
2. Do you spend more than $300 per month for an outside billing service?
3. Do you have a large number of insurance forms returned due to incomplete or inaccurate information?
4. Do you require more than five business days to complete and mail third party claim forms?
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6. Do you send out more than 250 patient statements per month?
7. Do you find that your cash flow varies widely from month to month even though the patient load is stable?
8. Do you frequently receive patient/third party inquiries about services performed?
9. Do you have a substantial number of patient accounts outstanding over ninety days?
10. Do you frequently receive requests for end-of-year statements?
11. Do you write off many patient accounts as uncollectable?
12. Do you experience a lack of continuity in office routine due to staff turnover?

According to the publication **Computer Talk for the Physician,** the benefits of computerization can be summed up in the terms **productivity** and **information.** Output per man-hour, i.e., productivity, is increased via the appropriate use of computer resources. The right computer system provides the means by which efficiency and accuracy are increased in the processing, filing, storing and accessing of information. This refers both to clinical, financial and practice management information.



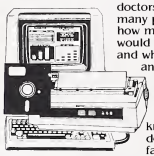
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Optimal Length of Hospitalization for Uncomplicated Acute Myocardial Infarction Is Ten Days

MICHAEL A. NEVINS, M.D., and
LEONARD J. LYON, M.D., Woodcliff Lake*

Whereas the usual length of hospitalization after myocardial infarction approximates 14 days, much evidence exists to suggest that patients whose early course is uncomplicated by significant electrical or mechanical dysfunction derive little or no benefit from prolonged hospital stays. Such patients can be discharged safely by day 10 or even earlier.

This article's rather dogmatic title is intended to be contentious, and to call attention to the fact that certain clinical conventions are based more on tradition than on sound scientific evidence.

In recent years, an abundant literature has developed indicating that low-risk patients can be identified within the first days after myocardial infarction and that early discharge of this group does not incur any increased risk.[1-10] The present study was designed to test the hypothesis that current practice pertaining to hospitalized patients with uncomplicated myocardial infarction does not reflect contemporary medical knowledge, and substantial savings in hospital costs and greater bed availability can be realized if physicians reset their goals closer to 10 days than the traditional standard of 14 days.

PATIENTS AND METHODS

Pascack Valley Hospital, a 250-bed community hospital, has averaged 230 admissions of patients with acute myocardial infarction in each of the past three years. One hundred consecutive patients who survived the first four days of hospitalization and who had been classified by their physicians at the time of discharge from the coronary intensive care unit as having sustained a "definite myocardial infarction" were studied retrospectively. This study group, in effect, comprised the unit's experience with acute myocardial infarction survivors during the second half of 1981.

The cohort was subdivided into two categories: A: "Complicated" and B: "Uncomplicated"; this was based on the patient's clinical course during the first four hospital days according to previously published criteria.[1] Such complications as shock, pulmonary edema, persistent hypotension, sustained sinus tachycardia, or supraventricular or ventricular tachyarrhythmias were required to place a patient in group A; those without any of these findings were placed in group B. An initial chart review was performed by a medical records librarian, but 80 percent of the charts later were analyzed by one of the authors in order to correct miscategorization after the first review. This process resulted in 17 patients being reassigned from group A to group B or vice versa. Although the 100 patients originally had been identified by their own physicians at the time of coronary care unit (CCU) discharge as having sustained a myocardial infarction, 22 patients were rejected because chart analysis failed to reveal objective enzymatic or electrocardiographic confirmation of this diagnosis to the satisfaction of the reviewer. This rather high percentage reflects some confusion in diagnostic

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criteria and terminology. For example, the presence of CK-MB isoenzymes in clinically ambiguous cases was associated with variable diagnostic classifications by the medical staff.

Of the 78 patients who had objective electrocardiographic and/or isoenzyme criteria for acute myocardial infarction, 48 were placed in group A and 30 were placed in group B (Table).

Our local experience approximates the national practice with mean durations of 13.4 and 4 days, respectively, for hospital and CCU care of uncomplicated infarcts. With the criteria employed in our small series, 40 percent of our patients were considered uncomplicated as compared to 52 and 53 percent in several large published studies.[2,3]

In this study, the fact that there was no significant difference in length of stay between group A and group B patients suggests that in their discharge planning the attending physicians did not distinguish between subsets of patients at high or low risk. Although the study was not designed to analyze after-hospital events, only one patient from group A and none from group B was readmitted during the six-month study period. The hospital mortality of 5.3 percent reflects the fact that the study group included only those who had survived the first four days and who were discharged from the CCU. An audit conducted in 1980 revealed an overall mortality for coronary care unit admissions with acute myocardial infarction of 10 percent.

Of the four patients who died, the three from group A had evidence of power failure during their early hospitalization and died 7, 14, and 24 days after admission. One patient from group B died suddenly on day 7. Several patients both in group A and group B were discharged in 10 or fewer days, the reasons for their early discharges including "psychotic agitation," "signed out against medical advice," "enzyme infarct," or "subendocardial infarction."

DISCUSSION

In recent decades there has been a steady decline in the length of hospital stay of patients who have sustained acute myocardial infarction. In 1969, Lown and Sidel editorialized, "It is our contention that the patient who does not exhibit any complications during the initial week of hospitalization does not derive special benefit by remaining in the hospital beyond the 10th to 12th day" but noted that this recommendation was about half of the usual length of hospitalization at the time.[4]

In 1976, an Ad Hoc Committee of the National Heart and Lung Institute addressed the issue of optimal duration of hospitalization for uncomplicated myocardial infarction and concluded that, in terms of prognosis and management, patients could be identified early who were at low risk for subsequent complications and, in this subset, 9 to 14 days hospitalization should suffice in most instances.[2] This study also noted that the range of average hospital stay was strikingly lower in the West and South than in the East where the average in 1972 had been 19.3 to 22.5 days.

A recent study based on questionnaires sent to 6,000 American physicians compared patterns of care in the past decade and observed that the median length of total hospital stay had decreased from an average of 21 days in 1970 to 14 days in 1979, the corresponding CCU experience showing a reduction from 4.5 to 3.5 days.[3]

In 1981, a study conducted by the AHA's Intersociety Commission for Heart Disease Resources attempted to establish standards for the care of patients with acute

TABLE
Experience with Myocardial Infarction

Group	No.	Hospital Deaths	Mean LOS (days ICU	Total
A (Complicated)	48	3	4.5	14.4
B (Uncomplicated)	30	1	4.0	13.4
Combined	78	4	4.3	14.0

myocardial infarction.[5] This group concluded: "It seer relatively safe . . . to discharge patients with uncomplicat acute myocardial infarction after approximately ten days hospitalization."

The European experience is instructive and suggests th even 10 days may be an unnecessarily long duration uncomplicated cases. As early as 1972, a report from Irela noted that 18 percent of 249 patients could safely be d charged by day 7; 62 percent spent 10 days or less in t hospital.[6] In a Scandinavian study of 383 patients, two-thir were uncomplicated after 3 days and these were divided in two groups: the first group was hospitalized for 8 days a the second group was hospitalized for 15 days. Three-mon followup revealed no differences in mortality, morbidity, work capacity.[7] In another study of 184 patients, 30 perce rapidly were mobilized and discharged after a mean of 9 da with one patient dying in the subsequent six-month follo up.[8] Similarly, a Danish study found that 48 percent of t 1,140 consecutive patients could be discharged safely on d 6.[9] In these reports, low-risk groups could be identified ear in the hospital course by virtue of the absence of indicato of electrical or mechanical dysfunction.

In this country, the group at Duke University Medic Center has been the most persistent advocate of ear discharge after myocardial infarction. In a retrospecti study published in 1975, they contended that patients wh had survived 4 days after infarction without complicatio had no late urgent complications whereas those with con plications during the first 4 days had a 51 percent incidenc of late problems.[10] In 1978, they prospectively confirme their earlier results and in this study discharged a subgrou of patients with no early complications after only 7 days. Th early discharge group, 30 days later, could not be differer tiated from their matched controls.[11] In 1982, their work wa extended to determine if these criteria could be corroborate in a community hospital.[1] Again, early identification of low risk patients was accomplished although physician practic in the community hospital did not appear to be affected b the earlier published results, the length of stay in th community hospital being 17 days as opposed to 11 days the medical center.

Certain subsets of patients might be considered at greate risk of reinfarction or extension. Thus, in a report of 42 survivors of acute myocardial infarction at three-mont followup the group at highest risk of reinfarction were thos who had sustained a prior anterior myocardial infarctio with a prevalence of hypertensive females who recently ha suffered anterior nontransmural infarction.[12] Marmor et a observed that 43 percent of patients who had suffered a initial nontransmural infarction exhibited recurrences a compared with only 8 percent of those whose initial infarc tion was transmural.[13] Those with nontransmural infarctio who reinfarcted had more than twice the mortality of thos who did not. In that study reinfarction was defined on th basis of secondary CK-MB and myoglobin peaks rather tha recurrent pain or electrocardiographic abnormalities. Rein farction tended to occur most often on about the tenth da

after the initial event and was most likely to occur in obese women.

Another smaller study failed to confirm a greater prevalence of patients with subendocardial infarction to extend but noted that the mean time for enzymatic elevation to occur was 4.6 days after admission.[14]

The late stage of hospitalization often is utilized to perform predictive tests such as low level exercise electrocardiography; however, these need not unduly delay discharge and several studies have described their safe use as early as seven to ten days after infarction.[15,16]

Although it is beyond the scope of this article, it should be noted that in some quarters enthusiasm has waned for methods of treatment that have been considered "state of the art." Indeed, the wisdom of hospitalizing all patients with myocardial infarction has been questioned and as a result of cost-effectiveness analysis, intermediate coronary care units recently have been characterized as representing "a promise unfulfilled."[17,18]

In the dialogue between physicians, health planners, and administrators over the issue of quality versus quantity of care, when the medical profession proposes that in the end better care is more economical, or that a shortened duration of hospitalization does not necessarily mean better care, it is important that we are able to support our case convincingly. If there are no clear medical justifications for retaining patients with uncomplicated infarction in the hospital for 14 days, the cost implications are obvious. Exceptions certainly arise and considerations other than the purely scientific may legitimately account for some prolongation of hospitalization in certain cases. Nonetheless, it behooves the medical profession to take a fresh look at its usual practices and to individualize patient care on the basis of identifiable risk.

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Fine-Needle Aspiration of Plasma Cell Tumors

DONALD ROTHMAN, M.D., YAYONE OLAIZOLA, M.D.,
JOHN BAKER, C.T., Red Bank*

Fine-needle aspiration of masses related to bone (skull, clavicle, and sternum) easily yielded, without complications, abundant atypical plasma cells upon cytological review and aided in more rapid clinical diagnosis and treatment of myeloma.

Fine-needle aspiration of various organs has been utilized for many decades. Traditionally, bone tumors, are subjected to open biopsy or are aspirated by large-bore Trefine-type needles.[1] Fine-needle biopsies of bony lesions are less well known, but are described in the literature.[2] According to Stormby and Akerman, it is not well known that bone lesions in advanced growths can be penetrated by a thin needle. Often, tumor tissue has extruded so it is accessible to fine-needle biopsy. The advantage of early safe aspiration of destructive, but accessible, lesions in our patients had led to more rapid diagnostic evaluation. In these three cases, two primary diagnoses were made within minutes and a secondary myeloma deposit was documented in a third patient.

METHOD

Using a No. 22-gauge, 1½-inch needle on a 20 cc plastic syringe in a syringe holder, the mass was fixed with the left hand while numerous thrusts were made into the depths of the lesion with the syringe held on 10 cc of suction. The suction was released with the needle still in the mass to equilibrate and then the needle was removed. Air then was reintroduced to the syringe and the material in the needle was blown onto glass slides, smeared, and air-dried. Diff-quik stains of the G-M-G type were used. Cytological review of the slides then could be made immediately. There were no complications.

CASE REPORT 1

Our patient was a 63-year-old man from a rest home who came to the office in October, 1979, with a two-month history of a left frontal mass. The patient did not describe any discomfort. In the office, a fine-needle aspiration biopsy was done revealing a monomorphic population of immature plasma cells. Under local anesthesia a surgical biopsy was done revealing a plasmacytoma and x-rays of the skull depicted defects. The serum electrophoresis showed a monoclonal gamopathy and the patient began treatment for multiple myeloma.

CASE REPORT 2

A 53-year-old woman who had known multiple myeloma required emergency cord decompression because of advancing neurological changes. A soft tissue mass overlying the sternum was surgically biopsied at an early stage, revealing no pathology. Subsequently, a fine-needle aspiration biopsy was done revealing numerous characteristic immature plasma cells consistent with multiple myeloma (Figure 1).

CASE REPORT 3

Our patient was a 62-year-old man who, over a three-month period, developed a painful right clavicular destruc-

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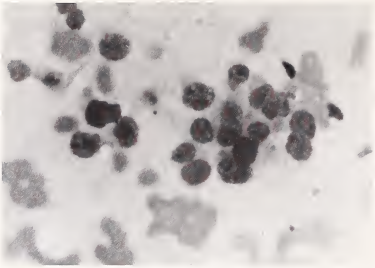


Figure 1—Immature plasma cells (diff-quik stain at 400 power).

tive bony lesion (Figure 2). A fine-needle aspiration biopsy showed mature, immature, and binucleated plasma cells (Figure 3) and an open surgical biopsy indicated a plasmacytoma.

DISCUSSION

Bony lesions are thought to be too hard for fine-needle biopsies. Often, there is a delay in making a definitive diagnosis by the time an open surgical biopsy can be scheduled. Fine-needle aspiration biopsy of numerous lesions of the skeletal system can be performed as the first step in the evaluation, even in an office setting without any pain or danger to the patient. In cases of plasmacytoma or multiple myeloma, monomorphic infiltrate of characteristic plasma cells can be identified with ease and a diagnosis made immediately.

Negative needle biopsies of suspected tumors may be due to a sampling error or fibrotic lesions with scanty tumor cells. Most clinicians improve their accuracy with experience. It is mandatory that close followup of negative biopsies be done. The lesion can be aspirated again since there is little pain and patient acceptance is almost universal. Finally, one can resort to core (Tru-cutt/Vim Silverman) or open surgical biopsies if necessary.

Complications are few. Needle tract dissemination has been described so rarely in the thousands of aspiration biopsies done as to not represent a contraindication. Pain is minimal. Bleeding from a No. 22-gauge needle puncture, even of vascular bone lesions, is uncommon and certainly would stop with firm pressure. Aspiration of masses overlying important viscera certainly should be sampled with care as to the needle puncture depth. Even so, a deep puncture usually is uneventful.

Therefore, it would seem useful to do preliminary sampling of suspected bone tumors with the aspiration mode because of its simplicity and lack of complications.



Figure 2—Right clavicular lesion.

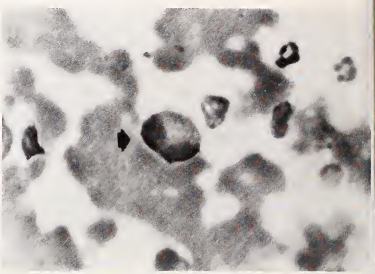


Figure 3—Binucleated plasma cells (diff-quik stain at 400 power).

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly·som·no·graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la·ten·cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af·ter sleep on·set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to·tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re·bound in·som·nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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Fine-Needle Biopsy of a Solitary Thyroid Nodule Arising during Pregnancy

MICHAEL H. GOLDMAN, M.D., BRUCE TISCH, M.D.,
AURELLA G. CHATTOCK, C.T., Englewood*

Solitary thyroid nodules always are of concern for malignant potential. Their development during pregnancy may heighten suspicion. Contraindications to thyroid scanning during pregnancy add to a diagnostic difficulty. Use of fine-needle biopsy combined with ultrasonography gives a direct, simple, and risk-free approach to this problem.

The discovery of a thyroid nodule always is of concern for potential malignancy. Whether a nodule's occurrence during pregnancy should heighten this suspicion is uncertain. Marchetta feels that the appearance of a nodule during pregnancy increases its likelihood of being malignant.[1] Cunningham, however, states that no evidence has been shown that solitary nodules or carcinomas occur more frequently during pregnancy, that most nodules are benign, and that adenomas and carcinomas have the same relative frequency in pregnant as in nonpregnant women.[2]

Furthermore, because of the prohibition of nuclear studies during pregnancy, the classification of a nodule into "hot" or "cold" cannot be made and the probability of the nodule being a cancer using this standard diagnostic technique is eliminated.

Therefore, it is the purpose of this report to point out the utility of fine-needle biopsy in conjunction with ultrasonography to investigate directly a nodule occurring during pregnancy and to recommend proper management.

CASE REPORT

A 31-year-old female (gravida 4, para 3) was referred because of the appearance of a solitary nodule at 28 weeks of gestation. No prior history of thyroid disease nor risk factors for cancer were given by the patient. The only notable physical finding was a 3 x 3 cm firm, solitary nodule on the left side of the thyroid. No clinical signs of thyroid dysfunction were observed. Thyroid function tests were normal for the stage of pregnancy. An ultrasonogram revealed a solid thyroid mass. Fine-needle biopsy showed groups of benign follicular cells, an occasional Hürthle cell, and a few scattered inflammatory cells. Thyroid suppressive therapy was recommended. However, the patient declined this advice.

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COMMENT

Whether a solitary thyroid nodule is malignant usually is inferred by historical information, physical examination, or, on occasion, blood testing. This has been reviewed extensively elsewhere.[3] Whether development of a solitary thyroid nodule during pregnancy increases the risks of it being malignant is uncertain.[1,2]

Because radioactive iodine can cross the placenta and can be trapped by developing fetal thyroid tissue, its use during pregnancy is avoided.

Recently, the utility of fine-needle biopsy has returned to the diagnostic armamentarium in this country and, in combination with ultrasonography, presents an easy, safe, and direct approach to thyroid nodule evaluation.[4] Its utility in pregnancy as shown in this case seems ideal. It should be emphasized that fine-needle biopsy has on the average about an 80 percent accuracy rate. False positive cytology for malignant cells are very uncommon; however, false negative cytology reports occur more frequently and should be integrated with other risk factors before making a therapeutic decision. Exact specificity and sensitivity of fine-needle aspiration has been reviewed recently and it compared most favorably to all other diagnostic modalities in the evaluation of thyroid nodules.[5]

Although thyroid cancer has not been shown to be influenced by pregnancy, nor is the discovery of a thyroid cancer a necessary proscription for therapeutic abortion, it earliest discovery is obviously important.[6]

Since the malignant potential of a thyroid nodule develop ing during pregnancy is unknown and its evaluation usin standard nuclear scanning is precluded during pregnancy the combination of fine-needle biopsy with ultrasonography presents a simple and sensitive alternative for its evaluation

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Pseudobridging Hepatic Necrosis in Infectious Mononucleosis

WARREN WERBITT, M.D., ROBERT JOYNES, M.D.,
WILLIAM HARRER, M.D., Camden*

An atypical case of infectious mononucleosis is presented. Special liver stains were necessary to differentiate acute hepatocellular necrosis due to infectious mononucleosis from chronic fibrosis or cirrhosis.

Liver involvement in infectious mononucleosis is extremely common, approaching 90 percent of all patients who contract this viral illness. Of all the patients with viral hepatitis, 90 percent will have enzyme abnormalities.[1] Although there is accumulation of large mononuclear cells in the parenchyma and about the portal tracts with foci of liver cell necrosis and acidophilic bodies, differentiation between the histological changes of mononucleosis and other viral entities and hematological entities at times is difficult. The following case presentation describes a patient with histological changes in the liver suggesting chronic liver disease as sequela of infectious mononucleosis; only special stains can make this differentiation.

CASE REPORT

A 27-year-old white female was admitted to the hospital with a history of pharyngitis, cervical adenopathy, and low grade fever of two weeks' duration. A week prior to admission, she had spiking temperatures to 103° with shaking chills. She was treated with ampicillin but developed a maculopapular rash on her chest; the antibiotic was stopped. Approximately five days prior to admission, she again had shaking chills, fever, and abdominal discomfort. At that time jaundice was noted and she was hospitalized. Her past medical history was unremarkable. She had no history of hepatitis nor exposure to anyone with hepatitis, but she had been exposed to an individual with mononucleosis.

Physical examination on admission revealed temperature 102.4°F, blood pressure 100/60, pulse 88, respirations 16. The sclerae were icteric. There was a fine maculopapular rash on her anterior chest wall and neck. The lungs were clear. The cardiac rhythm was regular; no murmurs or extra sounds were auscultated. Examination of the abdomen showed mild tenderness in the upper right quadrant and mid epigastric area. The liver was enlarged by percussion and the spleen was palpable. Rectal examination was unremarkable. The patient had anterior and posterior cervical lymphadenopathy bilaterally.

Laboratory data was: hemoglobin, 13.1, hematocrit 39; white blood cell count was 8.3 with 40% neutrophils and 60% lymphocytes. Peripheral smear showed a large number of atypical lymphocytes. Platelet count was 94,000. Total bilirubin initially was 6.3; alkaline phosphatase was 250 units; LDH was 750 units and SGOT 350 units. During the patient's hospital course, the bilirubin rose to a high of 11.4 mg/dl with a direct bilirubin of 7.1 mg/dl. The alkaline phosphatase rose to 725. Antinuclear antibody determination was positive to 1:40 dilution (homogenous pattern). Mono spot test was positive and heterophile was positive 1:56 dilution, after guinea pig absorption and negative after beef absorption. Urinary hemosiderin was negative. Gamma glutamyl transpeptidase was 850, which is markedly elevated. Urinalysis, prothrombin time, partial thromboplastin time, blood cultures, urine cultures, throat culture, latex fixation test, LE preparation, and serum haptoglobin levels were normal. Repeat heterophile studies were performed approximately ten days after the initial studies and showed the mono spot test to be positive, heterophile antigen to be positive, guinea pig absorption positive 1:224 and positive 1:7 after beef absorption.

Chest x-ray and electrocardiogram were normal.

Because of her atypical course, percutaneous liver biopsy was performed with a Menghini needle and tissue was stained with hematoxylin-eosin stain and with Masson trichrome stain. The hematoxylin-eosin stain showed changes consistent with the mononuclear changes seen in patients with hepatic involvement and mononucleosis, i.e.

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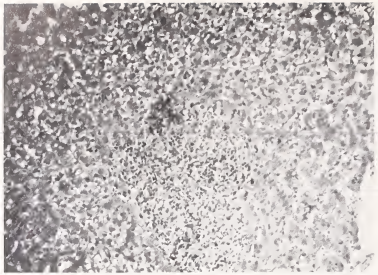


Figure 1—Hematoxylin-eosin stain of the liver suggesting destruction of the reticulum and chronic hepatic disease.

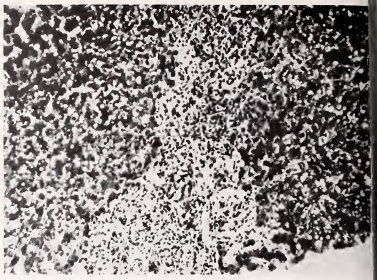


Figure 2—Masson trichrome stain demonstrates the inflammatory infiltrate without evidence of fibrosis.

large mononuclear cells both in the portal tracts and in the parenchyma. There was variation of liver cell size and an increase in the number of binucleated cells. Cholestasis was not present. There appeared to be more diffuse liver cell involvement than usually seen in infectious mononucleosis. There was focal "bridging" of inflammatory infiltrate between hepatic lobules suggesting the destruction of the reticulum framework and changes consistent with chronic disease (Figure 1). Masson trichrome stain of the hepatic tissue showed the inflammatory infiltrate between hepatic lobules, which was noted on hematoxylin-eosin stain, did not interfere with the reticulum framework and there was no element of fibrosis (Figure 2).

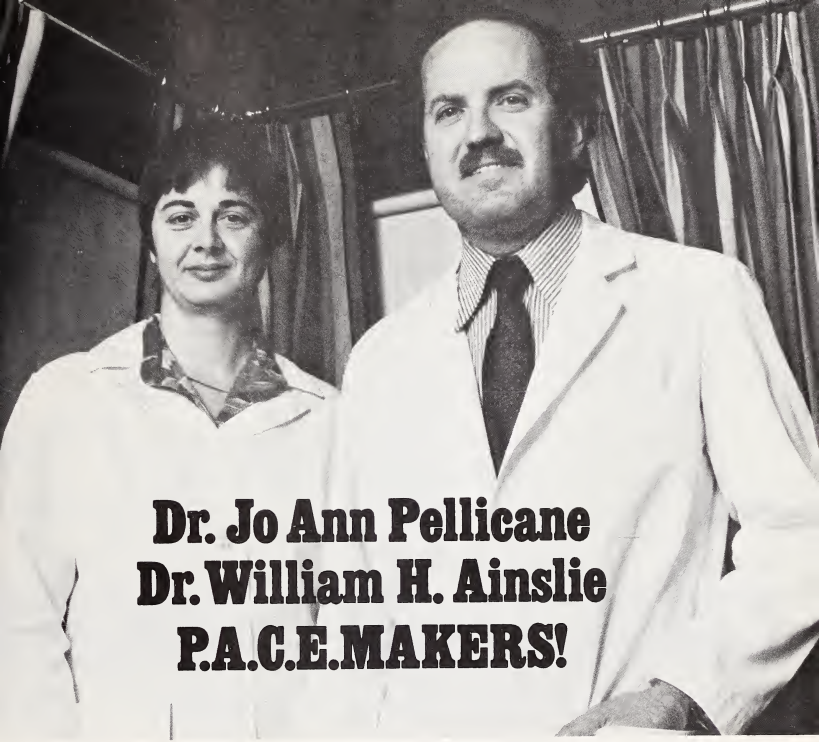
DISCUSSION

This case is atypical and suggests many unusual abnormalities usually not seen with infectious mononucleosis. The level of overt jaundice was extremely high, reaching 11 mg/dl. Although the hyperbilirubinemia probably is secondary to hepatocellular inflammation and necrosis, hemolysis may play a contributing role.[2] Most patients with infectious mononucleosis do not have clinical jaundice.[3] The increase in alkaline phosphatase is far more prevalent than the bilirubin elevation.[4] The characteristics of the typical liver biopsy of infectious mononucleosis show large mononuclear cells with deep staining basophile cytoplasm and there may be Kupffer cell proliferation. There is polymorphonuclear leukocyte and lymphocyte predominance and, at times, this resembles lymphatic leukemia. It has been reported that the architecture of the liver is preserved and that there is no fibrosis or cirrhosis.[5] A major feature of infectious hepatitis, central necrosis, is absent although focal necrosis may be noted. The liver cells may be replaced by acidophilic remnants.[6] It has been reported that it may take up to nine months before the hepatic tissue makes a total recovery. Dynamic ongoing inflammation and necrosis has not been reported. "Bridging," a specific term for that condition in which there is linking of the central veins to portal tracts or central veins to central veins by necrosis and/or the collapse of the reticular framework of the liver, does not occur in infectious mononucleosis.

Our case is unique because of the dense infiltration of inflammatory cells on hematoxylin-eosin staining which gives the appearance of subacute hepatic necrosis. This complication of infectious mononucleosis has not been described previously. Without confirmation with Masson trichrome stain, this patient could have been labeled as developing collapse of the reticular framework of her liver secondary to infectious mononucleosis. We urge that in all patients with hepatocellular changes, which occur in mononucleosis requiring liver biopsy, special stains (i.e. Masson trichrome stain and Silver stains) be performed to differentiate between benign inflammatory disease leading to complete recovery from ongoing subacute hepatic necrosis.

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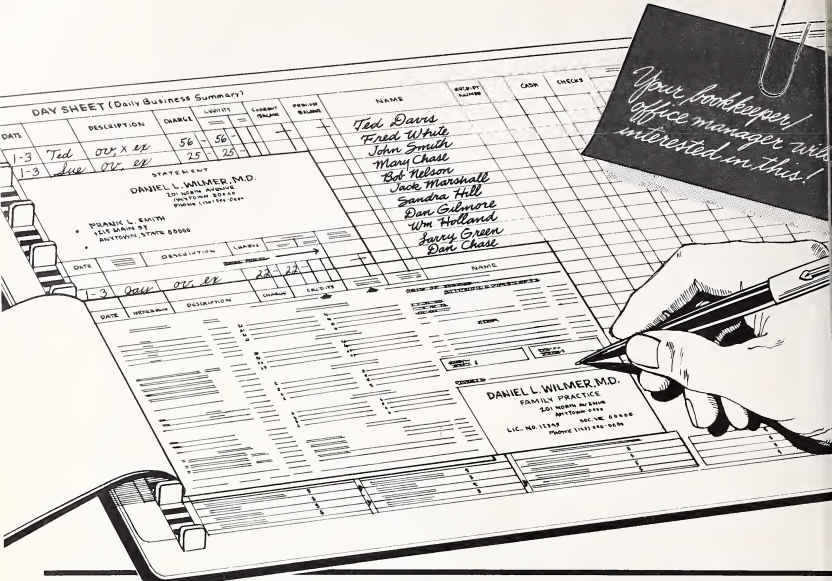
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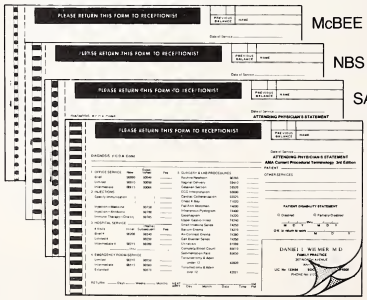
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SPECIAL ARTICLE

Hospital Design, Construction, and Renovation

FREDERICK J. MIHELIC, Newark*

Radical changes in hospital design and construction have come about because of certificate of need legislation, scientific needs, inflation, and humanistic considerations. Flexibility is the key word.

Rapidly changing technology, a complex web of codes and regulations, and demanding certificate of need requirements all have had a dramatic impact on hospital design and construction in the past decade.

Merely keeping abreast of evolving medical developments has become a full-time job, yet, some member firms of the New Jersey Society of Architects are doing just that while helping hospital administrators reduce expenditures and keep a lid on inflationary health care costs.

Hospital work has become one of the most complex design undertakings in the architectural portfolio. Medical treatment techniques and philosophies have changed substantially in recent years, primarily due to improvements in research and technology.

"Diseases once requiring extensive hospital stays either have been eradicated or now can be treated by drugs and inoculations," notes West Orange architect Gilbert L. Seltzer. "People are being hospitalized for relatively brief periods of time for ailments that once required long inhospital stays. This does not mean that existing beds are going empty, because improved insurance coverage has made health care service available to a greater percentage of the population than ever before."

Added to the design demands imposed by new techniques and philosophies, is the need to undertake and complete construction or renovation without disrupting normal hospital routine. Life and work patterns must be detailed thoroughly and understood before construction/renovation can begin.

According to Chester Philips, of Philips-Kaufman & Associates, P.A., Morristown: "The complexities of maintaining 24-hour operations during the transition to new or enlarged facilities requires sophisticated construction scheduling that is planned with a detailed awareness of staff functions (Figure 1).

"It also requires an implicit commitment to precise communication among the administrative, medical, nursing, and technical staffs and design professionals. Hospital design is the quintessential team activity."

Philip Collins, principal partner in CUH2A, a Princeton-based architectural and engineering firm, agrees with assessments ranking hospital work as perhaps the most challenging of all architectural projects: "Codes (exits, fire suppression, sterilization, biological containment, and ventilation) are always being upgraded, and ongoing technological and equipment breakthroughs happen so quickly that room design must be adapted to keep up with the changes. In addition, we constantly are working with problems of in-hospital traffic mobility, cleanliness requirements, and the need to complete work without disrupting normal hospital routine."

Hospital projects make up approximately 30 percent of CUH2A's current workload. This includes a $5 million renovation of the obstetrical floor of Saint Peter's Medical Center and, in joint ventures with other firms, an $8 million,

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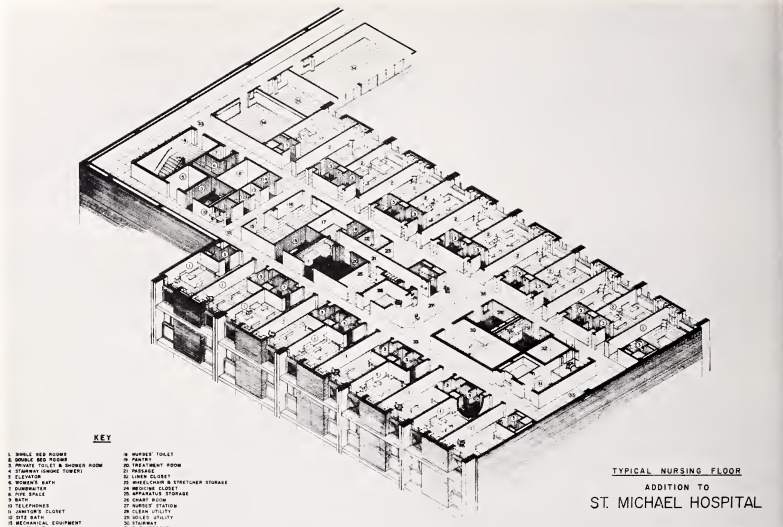


Figure 1—Typical nursing floor, Saint Michael's Medical Center, Newark. Philips-Kaufman & Associates Architects/Planners.

100-bed psychiatric unit to replace the Vroom Building at Trenton Psychiatric Hospital, and a $32 million addition to Middlesex General Hospital as it becomes the primary teaching facility for Rutgers Medical School of the University of Medicine and Dentistry of New Jersey.

Hospital construction costs have nearly doubled in the past decade and now range upwards of $125 a square foot. Operating rooms, radiology laboratories, and other areas requiring complicated mechanical/electrical systems are the most expensive construction items, absorbing between 40 and 45 percent of the budget. The price tag accelerates quickly on facilities of several hundred thousand square feet.

These prohibitive construction costs and the introduction of certificate of need requirements mean that very few completely new hospital facilities are going up anywhere in the country. Instead, administrators are renovating or expanding upon existing facilities at lower costs.

CERTIFICATE OF NEED

Perhaps the greatest restriction on new hospital construction—and even expansion—has been the introduction of certificate of need (CON) regulations required by both federal and state law. The thrust of these new government regulations is toward cost control and containment, in response to spiraling health care costs that have risen some 450 percent in three decades. The certificate of need is designed to promote a regionalization of hospitals, equipment, and services, thereby reducing or eliminating duplication. Officially known as Public Law 96-79 (or the Health Planning and Resources Development Amendments), the certificate of need regards individual institutions as elements in an overall system of state and regional health planning. It requires that the hospital applicant establish need and a viable source of funding before undertaking any new capital construction expense in excess of $125,000.

The legislation sets forth a broad criterion of standards and procedures to be used in determining need, all of which place increased emphasis on cost effectiveness and energy conservation. It has spawned extensive preplanning on the part of hospital administrators before work can be launched or even seriously contemplated, and it has generated early involvement by architects in the predesign or programming phase of a project.

"At The Eggers Group, we consider it an important part of the planning process to maintain contact with health system agencies and other reviewing bodies during development of programmatic materials and data required for the CON application," says architect Michael Conoscenti, Senior Vice-President in charge of the firm's Trenton office.

The firm won numerous awards for its work as supervising and design architect on the joint-ventured University of Medicine and Dentistry of New Jersey, Newark. This massive, $200 million, six-building complex stretches over 47 acres of urban renewal land and is the largest project ever constructed by the state of New Jersey.

Recently, the firm demonstrated the importance of architectural predesign involvement in a project when it helped secure a certificate of need for a $15 million expansion of Christ Hospital, Jersey City—after the program originally had been denied such authorization. The firm gathered the statistical and demographic data necessary to support the

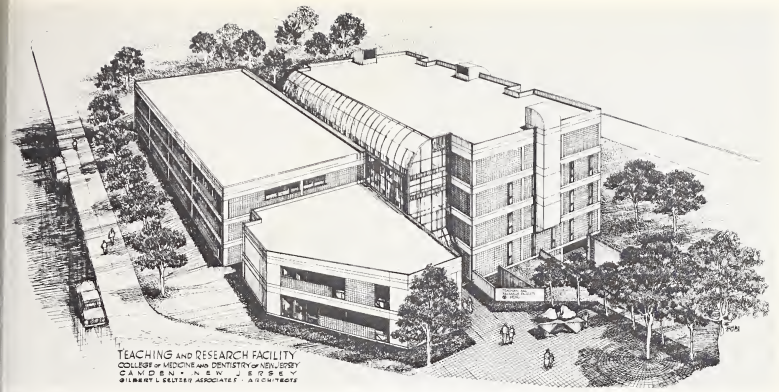


Figure 2—Teaching and research facility, University of Medicine and Dentistry, Camden. Gilbert L. Seltzer Associates/Architects.

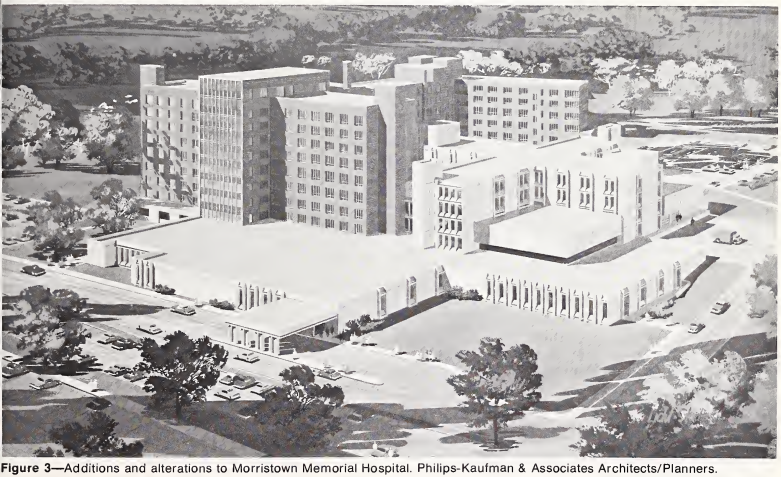


Figure 3—Additions and alterations to Morristown Memorial Hospital. Philips-Kaufman & Associates Architects/Planners.

proposed programs, and then carried through with presentations at public hearings and meetings during the review process. The project was ultimately granted a certificate of need based upon its functional programs and the cost estimate derived from predesign planning.

Other recent projects which followed predesign guidelines were St. Francis Medical Center, Trenton, and Saint Elizabeth Hospital, Elizabeth.

Despite its cost-effective objectives, the certificate of need can often be a mixed bag of benefit and bane, according to Chester Philips, whose Morristown firm has completed 23 major hospital projects in New Jersey during the past decade, totaling better than $90 million. It represents the largest volume of hospital construction work achieved by any New Jersey-based architectural firm.

"More often than not the procedure seems designed to obstruct improved health care rather than assist it," Philips muses. "In many cases the certificate of need procedure actually adds to construction costs (and through them hospital costs) because it delays construction, sometimes for years, which can be very expensive in today's inflationary market."

North Plainfield architect Robert E. Hopp agrees, saying that the average time it takes to obtain a certificate of need

is three years. "Such a delay is the most important factor in the escalating costs of construction or renovation," he states. "It's all so senseless, because most of the time is consumed in nit-picking bureaucratic delays. Worse, the ever-changing maze of regulations has resulted in many hospitals ultimately being designed to paper standards which in their translation may bear little or no resemblance to sound hospital practice. It is one of the reasons we are starting to see hospitals going under, and smaller institutions being absorbed by the large conglomerates."

Hopp runs what is essentially a one-man, technical-oriented operation, yet he has undertaken numerous hospital design projects, including the John E. Runnells Hospital in Berkeley Heights; Plattsburgh AFB Hospital; a proposal for a teaching hospital requested by the Peoples Republic of China; work on Memorial General Hospital, Union; Hunterdon Medical Center; and Jersey Shore Medical Center.

FLEXIBILITY IN DESIGN

Most architects agree that high costs and the severe restrictions imposed by certificate of need requirements have made flexibility a key ingredient in all hospital planning and design work. Through maximum flexibility, the architect can help insure that today's hospital will maintain mobility and ease of circulation, a therapeutic environment, and the capacity to adapt to tomorrow's technological changes.

"Perhaps the most important area of hospital design and construction is in the provision of proper circulation and mobility for the facility's entire population," Gilbert Seltzer contends. "That includes patients, doctors, nurses, staff, and family visitors. The architect must instill a feel for humanity in his client. Too often, family visitors are ignored and disregarded as the important ingredient they are in a patient's recovery process."

Seltzer Associates, one of three design firms responsible for New Jersey's huge University of Medicine and Dentistry complex (Figure 2), has developed prototypes for Army, Navy, and Air Force Mobilization hospitals throughout the world, as well as other important hospital projects, including those at Utica and Helmuth, New York.

Chester Philips reports that his firm's current hospital design accents three often neglected but basic necessities: 1) maximum designed-in flexibility, 2) aesthetic ambiance and technological efficiency to promote and enhance effective patient care, and 3) uninterrupted continuation of the hospital's vital services during alterations/additions/new construction (Figure 3).

"We support an institution's staff by providing space that is consistent with good medical, administrative, and nursing procedures," Philips says, "and by organizing the complex technical components of the facility in functional and efficient relationships.

"However, we believe that the architect's fullest consideration also should be given to creating a pleasing, comfortable environment for the patient. Established evidence supports the therapeutic contribution of color, texture, and good visual form to the security and well-being of the patient."

Likewise, The Eggers Group believes that hospital design must emphasize the psychological needs of its users—patients, staff, and visitors—and that cheerful, restful, and reassuring environments must be provided for all these groups.

"The internal organization of a hospital has considerable influence on its flexibility and adaptability," Conoscenti notes. "Although there is wide divergence in possible departmental organization, clear and well-defined circulation is essential to the workability of any plan. Different types of traffic—staff, visitors, patients, and clean and dirty supplies—must be separated to avoid confusion, cross infection, or psychological discomfort.

Given the need for constant change, the implementation of expensive technological breakthroughs, and rigid certificate of need requirements, are there ways that an architect can help reduce construction/renovation cost? Definitely!

"The best way for a hospital board to cut down on needless expenses is to engage the architect at the very earliest stage of discussions," says Robert Sussna, head of the Sussna Design Office, Princeton. "The architect should be made an integral part of the entire decision-making process."

Sussna, currently undertaking renovation work at Raritan Valley Hospital, said early involvement by the architect can help a board determine whether new construction is actually needed, or whether expansion, renovation, or upgrading will suffice. The architect also can judge if the potential site is sufficient for anticipated needs.

Good design features can save on operational costs as well, specifically in mechanical and electrical areas. "For example, the use of blanket and solution warming cabinets energized with inexpensive steam heat provides an accumulated savings over electrically heated types," Chester Philips states.

Compact structuring and the elimination of long, rambling corridors are two more ways of reducing hospital and ultimately medical costs, according to Robert Hopp. "We were able to cut 100 square feet of space from one hospital's original laboratory expectations. At $40 a square-foot, the savings can be substantial. By tailoring lab layouts around the placement and uses of equipment, we can also cut down on lost time and reduce hospital staffs."

In the final analysis, the most important ingredient in reducing hospital costs is the architect's thorough understanding of a client's needs, requirements, and long-term goals.

Nineteenth-Century Views on Blood Fluidity*

VINCENT J. CIRILLO, M.S., Rahway**

The development of the concept that the vascular endothelium produces a substance which maintains the fluidity of circulating blood is examined through the work of several 19th-century medical scientists: Turner Thackrah, Sir Charles Bell, Ernst Brücke, Benjamin Richardson, and Joseph Lister.

At the beginning of the 18th century it was believed widely that mechanical constriction of a wounded blood vessel was the chief factor in arresting hemorrhage.[1] Although the presence of a clot was acknowledged, it was thought to be more a result than a cause of hemostasis. In 1731, the French surgeon Jean-Louis Petit, best known for his invention of the screw tourniquet, awakened the medical profession to the realization that blood coagulation was the essential factor in the control of bleeding (Figure 1).[2] "Dans toutes ces différentes maniéres d'arrêter le sang, on voit que le Caillot est très nécessaire. . . ."[3]

The discovery that divided arteries were self-sealing and did not necessarily need to be closed mechanically was of enormous importance to surgery, and was the stimulus for further studies of the process of blood clotting, the most important of which were those of William Hewson, a pupil of the Hunters.

In the autumn of 1759, at the age of 20, Hewson journeyed to London, England, where he lodged with John Hunter and attended William Hunter's lectures in Covent Garden. Hewson's talents were quickly recognized, for he was left in charge of the dissecting room when John Hunter went abroad with the army in the spring of 1761, during the fifth year of the Seven Years War. By the following winter, Hewson had become a partner of the elder Hunter at the anatomical school in Litchfield Street.[4]

The partnership with Hunter ended shortly after Hewson's marriage to Mary Stevenson. Thereafter, Hewson opened his own school in Craven Street, but his brilliant career was to be short-lived. He died on May Day, 1774, at the age of 35 as a result of a disease which stemmed from a dissection wound.

Before Hewson's time, coagulation was ascribed to a mere conjunction of red corpuscles, and the clot was considered nothing more than a cohering mass of them. Hewson, in his classic treatise, *An Inquiry into the Properties of the Blood*,[4] showed that when coagulation is delayed, as for example by cold, a coagulable lymph, now called fibrinogen, can be separated from the blood cells. Further, he proved that the coagulation of this lymph was independent of the other parts. Coagulation, in his view, was due to the conversion of a fluid-coagulable lymph into an insoluble substance, later termed fibrin by the French, and not to a conjoining of erythrocytes.

In one of a series of remarkable observations, Hewson collected blood from sheep at slaughter (Exp. XXI), and noted that the first drawn began to coagulate in about two minutes. Blood taken later, as the animal became weaker, coagulated in less time, "till at last, when the animal became very weak, the blood, though quite fluid as it came from the vessels, yet had hardly been received into the cup before it congealed."[4]

Hewson presciently concluded from this and several similar experiments that the fluid properties of blood were somehow dependent upon the state of the blood vessels: "For when the vessels act more strongly than they do in health, the lymph is proportionably more thinned, and is less

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disposed to concrete; and when the vessels act more weakly than in health, then the lymph is proportionably thickened, and is more ready to concrete. . . . For such alterations in the strength of the blood vessels are always connected with those of the lymph. . . . "[4]

Despite much work, Hewson was at a loss to explain the action of blood vessels on circulating blood: "And although it must be admitted that it is very difficult to conceive how the blood vessels should do this, yet I should hope that ingenious men would not merely on that account reject my conclusion; but would consider, that . . . it is deduced from a number of experiments . . . for there may be powers in the animal economy that are not yet dreamt of in our philosophy."[4]

Hewson's illuminative work left as the key problem for 19th-century physiology that was so clearly expressed by Wharton Jones in 1842: "Why does the blood circulating in the vessels not coagulate?"[5]

Turner Thackrah, surgeon of Leeds, had addressed this problem two decades earlier in an essay, "An Inquiry into the Nature and Properties of the Blood,"[6] although he candidly admitted in the preface that his efforts only cleared away obstacles for future researchers and did not provide the final answer: "If in this only I have been successful, the science will be benefited. The labourer, who removes the rubbish on the scite [sic] of a projected building, raises not . . . the structure, but in preparing the way for the more able workman, he takes an office, though less respectable, yet not, perhaps, less useful."[6]

Thackrah noted that in most of the cases described by Morgagni in which the blood was liquid after death, the patient had died suddenly from some nervous system disorder. Also, he interpreted Hunter's famous examples of blood remaining fluid and incoagulable in people killed suddenly by lightning or in animals killed in the chase as due to nervous exhaustion, and unrelated to any inherent vital force in the blood.

In successive experiments to test his hypothesis that the fluidity of circulating blood was related to the innervation of the blood vessels, Thackrah ligated a section of the external jugular vein of a small dog and then removed it from the body. After the vein had remained at 100°F for 30 minutes, he punctured it and found the blood to be perfectly fluid (Exp. XLI). Over 15 hours later, a portion of the vena cava taken from the same animal was filled with blood from the jugular vein of a similar dog (Exp. XLII). On division of the blood vessel after 15 minutes, Thackrah noted that the blood had completely coagulated. "Thus . . . for an half an hour, blood remained fluid in a vein recently removed, while in the lifeless vein of the same animal, it was found firmly concreted in fifteen minutes. To what shall we attribute this striking fact, if not to the loss of the vessel's vitality . . . I conclude, therefore, that the vital or nervous influence, is the source of the blood's fluidity,—and its loss, the cause of coagulation."[6]

Thackrah's important contribution is that he focused attention on the blood vessel in the maintenance of blood fluidity in situ, and discarded Hunter's vague concept of a vital force (materia vitae diffusa) existing in blood itself which prevented its coagulation.

Hunter had, in fact, turned the interest of medical science away from the blood vessel: "[Since] it retains its fluid state while circulating . . . and coagulates when the vessels or the body dies, it might naturally be supposed that it was the life of the body or vessels which kept it fluid; we know, however, that life in the body or vessels does not hinder the blood from

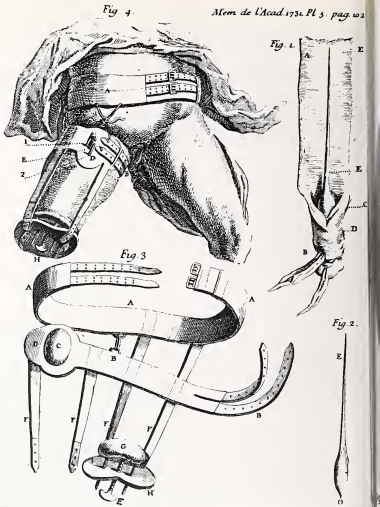


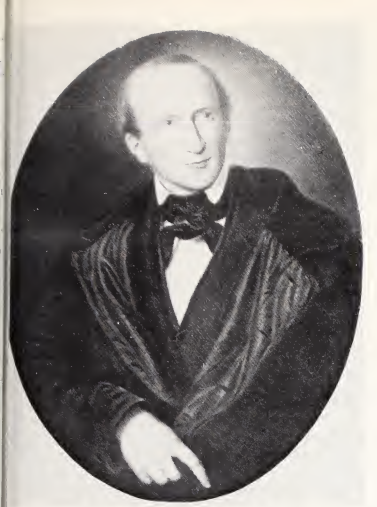
Figure 1—An illustration from Petit's "Dissertation sur la manière d'arrester le sang dans les hémorragies" (1731). The first figure depicts a section of a man's femoral artery that has been slit to expose a blood clot (E) in situ. The second figure shows the configuration of that clot, the nib (D) of which, in Petit's view, acts like a cork to stopper the opening of a wounded blood vessel.

coagulating under certain circumstances, but often rather excites coagulation; nor does death, in the body or vessels, in all cases become a cause of coagulation . . . there is, therefore, something more than the mere situation of the blood, surrounded with dead parts, that allows of coagulation; and that must be a something in the blood itself . . . To conceive that blood is endowed with life, while circulating, is perhaps carrying the imagination as far as it well can go; but the difficulty arises merely from its being fluid, the mind not being accustomed to the idea of a living fluid."[7]

Sir Charles Bell took Thackrah's concept a crucial step further in his *Institutes of Surgery:* "What has been omitted by all authors is, the relation which is established between the living coats of the artery and the living blood; that is the influence of the artery which preserves the blood fluid, and that, deprived of this influence, it coagulates."[8]

In another section of the same chapter subtitled, "Of Styptics, the Cautery and of Compression," Bell notes that styptics work because they injure the living coats of blood vessels, thereby facilitating blood coagulation.[8]

Bell observed that a sharply cut blood vessel usually bleeds more than a vessel ruptured by crushing. We now understand that the degree of vasoconstriction is greater in a traumatized vessel, and that the damaged tissue releases thromboplastin, a powerful activator of the extrinsic coagulation pathway.[9] Bell, on the other hand, interpreted blood coagulation in traumatic injuries as resulting from the loss of the vital properties of the blood vessels: "You destroy the life of the vessel, or injure it to that degree, that it no longer exercises its influences in preserving the blood liquid. . . . "[8]



igure 2—A portrait of Ernst Brücke (1819–1892) at age 29, one ear before he was appointed to the chair of physiology at the ienna Medical School. One of the most versatile physiologists f his day, Brücke's investigations covered all aspects of the ubject, including the luminosity of the eye in animals, honetics, the semilunar valves, and artistic anatomy. Reproduced with permission of Springer-Verlag, New York.

In his chapter on aneurysm, Bell writes that an aneurysm s not simply dilatation of an artery. Rather, the vascular ntima is damaged and layers of blood clots are present: "The nner coat alone has the property of preserving the blood luid, and no sooner is the inner coat chipped, than coagulum orms."[8] It is clear that Bell conceived that the vascular ntima plays an active role in preserving blood liquidity intra itam.

On December 15, 1855, Ernst Brücke,[10] the renowned rofessor of physiology at the Vienna Medical School (Figure 2), submitted an essay in competition for the fifth riennial Astley Cooper Prize. Upon his death, Sir Astley Paston Cooper (1768–1841) bequeathed a sum of £ 4000 to stablish the Astley Cooper Prize, a triennial award of £ 300 or the best original essay on a selected subject. The prize was pen to all members of the profession, British or foreign, and he surgeons and physicians of Guy's Hospital were appointed adjudicators of the prize. The topic selected for the 1856 prize, on the cause of coagulation of the blood, was one of six subjects originally chosen by Sir Astley himself.[11]

To test Thackrah's hypothesis, Brücke performed an experimentum crucis in which a terrier was suffocated by tying a hog's bladder over its mouth. The animal's brain was removed and its spinal cord destroyed by means of a wire. Seven and a half hours later the blood was still fluid, but coagulated when liberated. He concluded thereupon that the influence which keeps the blood liquid arises from the walls of the blood vessels, and not from the central nervous system, commenting: "It cannot be denied that the want of complete success of Thackrah is attributable to his having confounded the action of the great nervous centres with the peculiar action of the walls of the vessels."[12]

Brücke observed that the vascular intima usually is ruptured at the spot where a ligature is applied, and that the coagulum always begins at precisely that spot.[12] The importance of an intact endothelium for the preservation of the liquidness of circulating blood was emphasized: "In sound vessels . . . the blood remains fluid."[12]

To demonstrate that coagulation readily occurs when one prevents contact of the blood with the vessel walls, Brücke ligated the bulbus arteriosus of a turtle heart (Emys europaea), opened the pulmonary artery, and inserted into it a small glass tube. He then loosened the ligature, allowing blood to flow through the pulmonary artery. Afterwards, he tied the aorta, carotid, subclavian, and pulmonary arteries. The heart was removed and examined 24 hours later. Although the blood remained fluid in the heart and other arterial trunks, the blood in the pulmonary artery was firmly coagulated.[12]

Although Brücke used cold-blooded animals for convenience, he was convinced that the walls of the blood vessels of mammalia also must possess the power of keeping blood fluid. "Blood continues fluid in the sound and living vessels, but it coagulates in dead ones . . . the vessels of the living body preserve the blood in the fluid state by means of a peculiar action which vanishes with their life . . . we are compelled to assume that the walls of the vessels are not indifferent to the blood, but that they counteract its tendency to coagulate by a peculiar virtue inherent in them. In what this virtue consists, I am unable to say."[12]

Brücke provided experimental evidence to support Bell's hypothesis that the walls of the blood vessels play an active role in maintaining blood fluidity.

Notwithstanding the scientific merit of Brücke's essay, the Astley Cooper Prize of 1856 was awarded to Benjamin Ward Richardson, Professor of Forensic Medicine at the Grosvenor Place School of Medicine in London, for his discovery of that "peculiar virtue" which maintained blood fluidity: ammonia.[13]

Richardson repudiated the réchauffé theories of blood coagulation: loss of temperature (Plato, Aristotle, and Hippocrates), exposure to air (Hewson), vital force (Hunter), and nervous influences (Thackrah). In their place, he substituted two novel propositions: first, that the essential part of the process of blood coagulation consisted of the evolution of some volatile principle, and second, that his volatile principle was ammonia. Coagulation occurs, Richardson reasoned, when the fibrin, previously held in solution in the serum by virtue of the alkalinity imparted by the ammonia, is transformed from a fluid to a solid condition.[13]

An exhaustive series of experiments was carried out to prove that ammonia was that hitherto elusive principle of nature which sustained the fluidity of circulating blood.

First, Richardson sought to prove that ammonia was present in liquid blood. In one experiment (Exp. CCXCVI), air was bubbled through ox blood sealed in a Wolf's bottle which was connected in series to a Liebig potash-bulb containing pure hydrochloric acid. After the blood coagulated, the acid was decanted into an evaporating dish, platinum perchloride was added, and ammonium chloride crystals were deposited.[13] In another study (Exp. CCCIV), he stirred sheep's blood and held a microscope slide moistened with hydrochloric acid over it. The slide was dried afterwards over a spirit lamp, and ammonium chloride crystals were identified.[13] This experiment was repeated using human

blood (Exp. CCCX) with the same results.

Next, Richardson added ammonia to blood to determine if this chemical would alter coagulation (Exp. CCCXXIII): "One fluid ounce of blood from [a] dog was received into a bottle containing one grain of ammonia in ten minims of water. No coagulation took place for several hours . . . The blood corpuscles . . . were unaltered."[13] This information later was to prove useful to Richardson, a forerunner in the field of blood transfusion, when he successfully injected blood held fluid by added ammonia into the veins of animals and man.[14]

Concerning the concentration of ammonia needed in the normal circulation to prevent coagulation, Richardson stated: "I opine, from all my experiments, that a proportion of 1 part of alkali to 16 of fibrin . . . would be sufficient for retaining the perfect fluidity of normal circulating blood."[13]

Unfortunately, the critical question as to whether ammonia was produced by the vascular endothelium or elsewhere in the body was left unanswered. Modern studies have revealed that the gastrointestinal tract is the major source of blood ammonia. Intestinal ammonia, produced by bacterial deamination of undigested dietary protein and bacterial hydrolysis of urea, enters the portal vein and is transported to the liver where it is rapidly detoxified by conversion to urea. Patients with advanced hepatocellular disease, extensive portal-systemic collateral shunts, or both, fail to metabolize ammonia, thus allowing it to accumulate in the blood. Hyperammonemia is a serious consequence which has been associated with the development of hepatic coma.[15]

Although his ammonia theory was to find a fate similar to that of the hypotheses of Hewson, Hunter, and Thackrah, Richardson later was to gain fame through his study of the relationship between chemical structure and physiological action (1863–1871). This work, for which he was knighted in 1893, was to prove of inestimable value in the subsequent evolution of experimental pharmacology.[16,17]

When, in 1858, Joseph Lister amputated the right leg of a six-year-old girl suffering from gangrene, he noted that the autochthonous blood clot extended down the anterior tibial artery as far as the commencement of the gangrene: "The primary disease was inflammation of the arteries, accompanied by coagulation of the blood within them, obstructing the supply of nutrient fluid, and so inducing death of the lower part of the limb."[18] Lister commented that Richardson's theory was inadequate to explain the coagulation that occurs in arteritis or phlebitis: "How can the fact that the wall of the vessel is inflamed determine, on simply chemical principles, the evolution of ammonia from the blood within it?"[18]

In order to investigate the cause of coagulation in phlebitis, Lister injured the endothelium of a subcutaneous vein in a sheep's foot with caustic ammonia. Blood then was allowed to flow through; it coagulated, while blood in adjacent parts remained liquid. He, therefore, agreed with Bell and Brücke that the blood vessels must somehow participate in the maintenance of blood fluidity. "It might be imagined, either that the blood has a natural tendency within the vessels to comport itself as it does when outside the body, and that this tendency is counteracted by an active operation of the living tissues, or, that . . . the living tissues were destitute of such action, and simply neutral in their conduct towards the blood. Of these, the former has always appeared to me the more likely . . . "[18]

In subsequent work, Lister separated plasma from horse blood and acidified it with dilute acetic acid. Since the plasma remained perfectly fluid for a long time, he stated that the theory attributing the coagulation of blood to the escape of ammonia was erroneous. In response to this statement, Lister received a letter from Richardson criticizing Lister's technique. In his reply, dated December 17, 1859, Lister described an experiment which, in his view, obviated Richardson's objection.[19]

In commenting most favorably on Brücke's essay, Lister states: "I find that the principle which he advocates—viz. that the fluidity of the blood within the living body depends upon an action of the walls of the vessels upon it—is supported by many facts which he has observed in the chelonian reptile, very similar to what I have made out in mammalia."[18]

On June 11, 1863, in his Croonian Lecture delivered before the Royal Society of London, Lister went into wearisome detail concerning his experiments to test the validity of Richardson's hypothesis, concluding that: "The ammonia theory is to be discarded as entirely fallacious . . . and I may say, for my own part, that it has cost me an amount of experimental labour of which the illustrations brought forward this evening convey but little idea."[18]

Lister admitted that he was previously inclined to believe that blood vessels in some way actively prevented coagulation. But, by 1863, this notion had been swept away as a result of his recently acquired understanding of the remarkable influence ordinary solids exerted upon blood.

In a typical experiment, Lister inserted a glass tube into an ox vein until it completely filled with blood. The tube then was sealed by collapsing a piece of gutta-percha attached to its inserted end. In a comparative test, ox blood was poured into a similarly constructed tube. Both tubes were left undisturbed for some time. After 3½ hours the poured blood was firmly clotted. However, the tube in the vein, examined several hours after its insertion, contained only a circumferential clot; the major part of the blood in its interior remained fluid. In this instance, only the circumferential layers of the blood had come into contact with the foreign solid, whereas in the other case, though poured quickly, all parts of the blood made contact with the glass. Lister interpreted his results as follows: blood vessels do not actively inhibit coagulation. Rather, the opposite obtains; viz., ordinary matter actively promotes coagulation. "The blood, as it exists within the vessels, has no spontaneous tendency to coagulate, and therefore . . . the notion of any action on the part of the blood vessels to prevent coagulation is entirely out of the question. The peculiarity of the living vessels consists not in any such action upon the blood, but in the circumstance . . . that their lining membrane, when in a state of health, is entirely negative in its relation to coagulation . . . and fails to cause that . . . catalytic action which is produced upon the blood by all ordinary matter. The great peculiarity of inflamed parts in relation to the blood . . . consists in a tendency to induce coagulation in their vicinity . . . the affected tissues have lost for the time being their vital properties, and comport themselves like ordinary solids."[18]

On May 4, 1891, in an oration, "On the Coagulation of the Blood in its Practical Aspects," Lister reconciled his earlier published views on the active (1858) and passive (1863) roles of blood vessels in maintaining blood liquidity. His new hypothesis was based upon observations he had made three decades earlier; viz., that blood of mammalia coagulates in the heart and principal arterial and venous trunks within a few hours of death, but retains its fluidness for days in the smaller vessels: "I believe, therefore, that although in the

larger vessels the vascular walls are negative as regards the coagulation of the blood, in the capillary system there must be potent agencies counteracting any tendency to clotting induced by abnormal conditions, and capable even of dissolving fibrine [sic]."[18]

Investigations in this century have demonstrated that postmortem blood often is found to be completely fluid and uncoagulable in the limb veins while firmly clotted in the heart. Fibrinolysis in mortuo accounts for this phenomenon. Interestingly, in regard to Lister's comments, there appears to be an inverse relationship between fibrinolysin activity and the diameter of the blood vessel.[20]

Despite years of study, Lister felt that his experiments gave only an imperfect glimpse of the operation of mysterious but potent forces peculiar to living blood vessels, "forces which I suspect will never be fully comprehended by man in the present state of his existence, and the study of which should always be approached with humility and reverence."[18]

Studies of blood fluidity per se were of minor interest to 19th-century pathology. Of greater concern was the general relationship of inflammation to the phenomenon of thrombosis.

The concomitant occurrence of intravascular clots and phlebitis led Jean Cruveilhier, who held the first chair of pathology in the Paris Faculty (1836), to relate the two processes to the extent of asserting that all inflammation arose from some kind of blood coagulation.[21]

Cruveilhier's theory received its deathblow from Rudolf Virchow who demonstrated that coagulation commonly occurred in the absence of detectable inflammation. Moreover, the reverse situation also was true. Virchow concluded, therefore, that the inflammatory state did not cause blood clotting. In his view, the coagulum occluding the lumen of the vein was "in no wise dependent upon the condition of its wall."[22] Rather, sluggishness of blood flow was the principal factor in the genesis of intravascular thrombi.

Since coagula often were found adhering to perfectly healthy intima, Virchow reasoned that these clots originated from morbid processes occurring elsewhere in the body, and were dragged to their present location by the blood current.[23] From these and numerous other observations between 1846 and 1856, Virchow constructed his doctrine of embolism. Rarely in history has a pathological doctrine of such magnitude been so closely associated with the work of a single individual.

At the turn of the century, William Henry Welch summarized the current knowledge of thrombosis in a lengthy essay for Allbutt's *System of Medicine*.[24] Welch wrote that it now had become universally recognized that the endothelial lining of the vascular channels exerted an influence of the first importance in maintaining the fluid state of circulating blood. This action appeared to be partly physical and partly chemical. While the smooth, nonadhesive inner surface of the vessels was the primary physical characteristic, Welch granted that "we have very little definite information about any chemical activities of the normal vascular endothelium concerned in the preservation of the fluidity of the circulating blood . . ."[24]

Indeed, the technology of the time was inadequate to the task of isolating and identifying submicrogram quantities of biologically active substances from the vascular endothelial cells.

It is only within the last decade that prostacyclin, the most powerful naturally occurring inhibitor of platelet aggregation known, has been isolated from the vascular intima.[25] Evidence for a physiological role for prostacyclin now is so substantial that Richard Gryglewski has stated that "conditio sine qua non for the formation of intraarterial platelet thrombi is the inability of endothelial prostacyclin synthetase to generate enough prostacyclin."[26] Indeed, a prostacyclin deficiency may be important in the pathogenesis of some forms of microvascular thrombosis.[27]

Is prostacyclin that elusive "peculiar virtue," sought by Brücke, which maintains the fluidity of circulating blood? Presently, the data in support of this thesis, although not conclusive, are most compelling.

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Rehabilitation

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In the field of alcoholism and drug abuse treatment, there is a relatively uniform consensus that the ideal management of the new case includes a variable period of time in a residential rehabilitation program.

The timing of this admission depends on the presence or absence of the need for a period of acute detoxification and/or the ability of the physician-patient to arrange for the coverage of patients during an absence from active practice.

For those who undergo inpatient detoxification, the ideal arrangement is to move the physician directly into the rehabilitation program without any time lapse. Things always are not ideal! It may be necessary to interrupt the program briefly, at this point, to allow the newly "detoxed" physician time to make suitable coverage and family arrangements. No more than four to five days should be required at this point.

For the physician whose condition is stable and for whom detoxification was not required, prompt admission to the rehabilitation program is preferred. Again, a few days may be allowed to prepare for the time away, but once again, no more than four to five days should be allowed if at all possible.

There is an inverse ratio between the time delay of admission and the continued willingness of the "reluctant patient" to follow advice no matter how good, expert, or well intentioned it may be. One must "strike while the iron is hot."

While there is uniformity about the need for a good rehabilitation experience as the ideal initiation into a "substance-free" life, there is considerable variation of opinion about the duration of time required for this phase.

Our New Jersey program is not integrated closely with any treatment facility. This makes us free to select the facility for each physician that best matches the specific illness and needs.

There are many excellent programs in New Jersey, in neighboring states, and throughout the country. Among these programs, the time frame for the rehabilitation experience varies from three weeks to four months and, occasionally, may be even longer in a very severe case.

The Georgia Program, under the direction of Doctor Doug Talbot, has a mandatory four-month course that includes intensive rehabilitation, a sojourn in a half-way house, and a period of work in a treatment facility to enable the physician to experience the "mirror image" of his own impairment in the patient he confronts.

Not all of the workers in the field share this position. Most programs begin with a four-week rehabilitation experience for the alcoholic physician and a six-week program for the drug abusing physician.

The longer programs are available at all times and can be used in the event that the physician has not done well during the shorter programs or for the relapsing physician. We do not have good statistics to document that the results are any better with longer initial treatment.

Another important factor in the selection of a suitable rehabilitation program is its aftercare program. The better programs all have a well-structured aftercare program usually continuing for three months after discharge. This generally requires a weekly return visit by the physician-patient.

Proximity of the program to the physician's home is an important factor in the accessibility of the recovering physician to this key part of treatment. For this reason, our committee prefers to use facilities that are within reasonable driving distance from the doctor's home, rather than sending our clients across several states to some of the programs with a national reputation.

Family therapy usually is an important part of these programs during the residential and the aftercare phases. These same considerations of distance and accessibility apply to the family if they are to participate effectively.

"An intensive educational and therapeutic experience" would best describe the basic principle of rehabilitation.

There are two essential goals to this phase of treatment. The first goal is to provide the physician-patient with an indepth education about the nature of alcoholism or drug abuse as a primary disease. In an earlier article, the failure of our sophisticated medical education system to teach its students about these diseases was discussed. This facet of the rehabilitation program is so important that I occasionally have convinced reluctant physicians to look upon it as an investment in a "crash" CME course in substance abuse that will put them way out in front of most of their "uneducated" colleagues.

The nature of the disease, its insidiousness, its complica-

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ions, the massive denial that is an integral part of this illness, s predictable response to appropriate therapy, and its xcellent prognosis need to be explored thoroughly.

The second goal is to assist the recovering physician in the evelopment of the necessary skills to cope with the stresses nd the pressures in his/her personal and professional life in mature and intelligent manner without the "escape" or the crutch" that the "chemical of choice" has provided. One nust prepare for a new lifestyle with abstinence from all nood-altering chemicals as the essential cornerstone.

"Another important factor in the selection of a rehabilitation program is an aftercare program."

This requires a major adjustment in living patterns and hese skills need to be taught carefully and incorporated into he physician's defense armamentarium.

Different rehabilitation programs have a style and technique that are special, yet there is a rather consistent program that emerges when they are compared. The programs all offer a structured daily schedule in which the residents participate in a series of events that occupy the major part of their waking hours. Formal lectures, audiovisual presentations, individual and group counseling, study assignments, "rap sessions," and planned periods of rest and recreation fill the busy schedule.

The patient's denial is dealt with early in the program and is penetrated rapidly by fellow-patients who, perhaps better than anyone else, can see right through this defensive mechanism. This is one of the most important steps in treatment and needs to be completed successfully in the rehabilitation program if the physician is to come to grips with the disease and its treatment.

What most of these programs lack in ambience is more than made up by the intense dedication of the personnel who have chosen to devote their careers to this field. The loving concern of the staff for the clients is evident quickly.

The recovering substance abuser finds himself/herself in an environment that does not consider him/her some form of moral leper who should be shunned. The abuser is afforded the respect that is due to any suffering human being who is the victim of a disease that he/she did not want and cannot ignore. One's dignity as a human being is honored and accommodated.

One of the major problems in dealing with physician-patients in these programs is to convince the physician of the need to give up the role as the healer while in treatment, to accept the reversal of roles, and, indeed, to become the patient.

It only is when the physician learns to stop interfering with the treatment, that he truly can succeed. There is a tendency in the impaired physicians movements throughout the country to suggest that rehabilitation programs that are designed specially for physicians may be preferable to "open" programs that ignore social, educational, or professional status. I must confess my personal bias is that I am not convinced this is true. I believe physicians are human beings first and physicians second. As such, they are humanly prone to these diseases—"impaired persons" who happen to be doctors. While a part of their rehabilitation should address their special problems and concerns as physicians, the major issues in diagnosis and recovery are the same at all levels. My own experience and bias is that the best recovery occurs when all participants put aside their special distinctions and interact on the common ground of their shared disease.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physician Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately, the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

WHAT IS YOUR OPINION?*

Digital Subtraction Angiography

JEFFREY L. KAUFMAN, M.D., New Brunswick**

The review of digital subtraction angiography (DSA) by Mattern et al. (March, 1983) deserves commentary from the standpoint of a vascular surgeon.

DSA is a new technique, which is highly dependent on positioning and patient cooperation. DSA images may be difficult to interpret in regions of marked density contrast with soft tissue, such as gas or bone. The "atlas" of radiographic signs for DSA does not yet exist. Early experience has confirmed that DSA does not yield equivalent imaging to conventional angiography.[1,2] Only one small series to this date has compared surgical pathology with DSA findings.[3] The overall accuracy for 31 specimens was 93.5 percent. In no large series has the sensitivity and specificity of DSA been defined.

That two of the author's illustrations may be subject to alternate interpretation confirms the difficulty with this new technique. Figure 3 has an arrow pointing to an "ulcer." As well described recently by Lusby et al., the serious pathology likely is slightly more proximal in the internal carotid artery, an area of complex ulceration with an undermined flap.[4] In Figure 4A, the authors fail to note the filling defect beyond the left carotid stenosis. I suspect an adherent thrombus at this site, as is frequently seen in the area of disturbed flow beyond a high-grade stenosis.[5]

Although DSA has utility in such diverse problems as aortic aneurysms, renovascular hypertension, and followup evaluation of peripheral reconstructions, cerebrovascular disease commonly is seen as its major indication. DSA should be used in conjunction with a vascular laboratory for greatest cost effectiveness.[6] In asymptomatic patients with bruits, only those with vascular laboratory evidence for a hemodynamically significant stenosis need DSA. Even then,

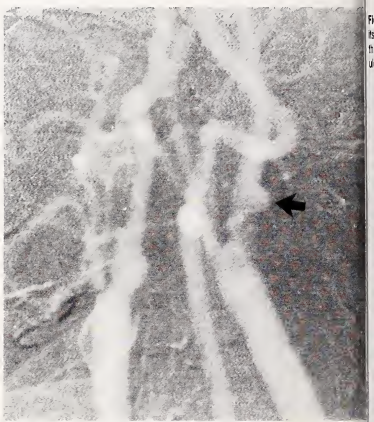


Figure 3—Significant stenosis with definite ulcerated plaqu (arrow) in the proximal left internal carotid artery.

*We encourage our readers to write opinions on topics of interest Send your opinion to Editor, *The Journal,* MSNJ, Two Princes Road, Lawrenceville, NJ 08648.

**Dr. Kaufman is Assistant Professor of Surgery, UMDNJ-Rutger Medical School, New Brunswick.

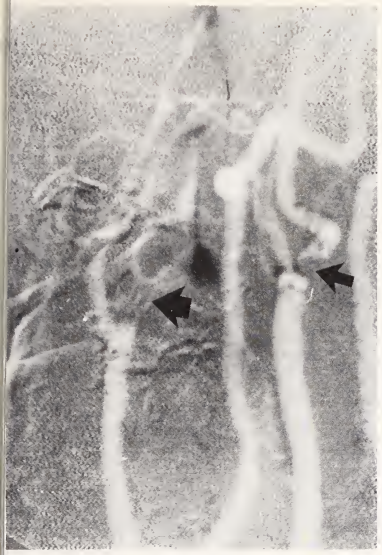


Figure 4A—Total occlusion of the right internal carotid artery at its origin (large arrow). On the left, there is a critical stenosis at the origin of the internal carotid (small arrow) as well as tiny ulcerations.

the need for conventional angiography is not obviated: Until larger series from major centers have been reported, carotid reconstruction should not be performed on the basis of DSA alone. For symptomatic patients, in particular those with vascular laboratory evidence for bilateral disease, conventional angiography is necessary. Notably, the problem of insufficient resolution in DSA (0.8 mm in the Philips DVI® machine with a 9-inch tube and 256 x 256 matrix) becomes significant in the assessment of ulcerated plaques, where classification on the base of angiographic size and complexity has been found to be of prognostic significance.[7]

In summary, DSA is a technique in its infancy and, therefore, not to be used indiscriminantly. I fear that the indications for DSA are not as broad as commonly expected. In particular, DSA should not be employed without noninvasive vascular laboratory studies and consultation with the surgeon who may be called upon to treat the findings, as conventional angiography may yield the best data.

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Trustees' Minutes April 29, 1983

A regular meeting of the Board of Trustees was held on April 29, 1983, at Resorts International Hotel and Casino, Atlantic City. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Report of the President ...

(1) Medical and Chirurgical Faculty of the State of Maryland ... Noted that Dr. Slobodien believes the relationship between MSNJ and hospital medical staffs of New Jersey hospitals would be enhanced by the formation of a special committee of hospital medical staff representatives as established by the Medical and Chirurgical Faculty of Maryland.

(2) Committee on Biomedical Ethics; Ad Hoc Committee on Women Membership ... Noted that the Committee on Biomedial Ethics and the Ad Hoc Committee on Women Membership were established.

Report of the Executive Director ...

(1) MSNJ Financial Statements ... Reviewed and approved the financial statements for the period ending March 31, 1983.

(2) Meeting with Commissioner of Insurance ... Noted that during the meeting of Doctor Slobodien, Peter Sweetland, and Mr. Maressa with the Commissioner of Health, two major topics were discussed: a) Blue Shield service benefits; the Commissioner stated that he plans to look into the situation; b) automobile no-fault law and proposed amendments; the Executive Committee and Chairman of the Council on Legislation plan to meet with the trial lawyers of the New Jersey Bar Association to discuss the law.

(3) MSNJ Paid Membership ... Noted that total paid membership (6,812 members) as of April 28, 1983, compares favorably with the 1982 figure.

(4) S-566—Licensing and Regulation of Athletic Trainers ... Postponed a final decision on MSNJ's position on the legislation until the reorganization meeting.

(5) Impaired Physicians Program ... Authorized the expenditure of $500 for honoraria to guest lecturers participating in the educational program developed by Doctor Canavan to train physicians who volunteer to assist in the work of the impaired physicians program as monitors and intervenors.

New Jersey Hospital Association ...

(1) Mobile Intensive Care Units ... Noted that 24 hospitals currently are operating 35 Mobile Intensive Care Units (MICU), and approximately 50 percent of the population of New Jersey is covered by MICU services, and an additional 20 hospitals are scheduled to come into the system with 24 more vehicles which would cover from 85 to 90 percent of the population. Learned that discussion concerning maintaining reimbursement under Part A of the Medicare waiver is under discussion.

(2) Skilled Nursing Facility Reimbursement ... Was advised that the new Tax Equity and Fiscal Responsibility Act (TEFRA) no longer distinguishes between Medicare cost limits for hospital-based and free-standing facilities and that retroactive to October 1, 1982, hospital-based SNF units will be reimbursed at a lower rate that will result in a significant revenue loss for some hospitals. Noted that affected hospitals learned of their right to appeal and several have done so. Noted that a report on this subject is due before the end of 1983.

(3) Definition of Death ... Noted that the Board of Trustees of the Hospital Association has adopted a position of opposition to **S-140—Russo, Uniform Determination of Death Act.**

Note: The bill has passed the Senate and is in the Assembly Judiciary, Law and Public Safety Committee. No action has been taken on the substitute bill offered to the Committee by the Hospital Association.

(4) Facility Definition ... Noted that the New Jersey Hospital Association has completed its investigation of the many free-standing health care facilities that have opened in New Jersey and their report is being finalized.

(5) Renal Dialysis ... Noted that 17 certificates of need for over 100 new stations were filed with the Department of Health, and the State Health Coordinating Council and the State Department of Health accepted all but two applications for new stations.

Committee on Medicaid ... Postponed consideration of the Medicaid Family Health Plan until further information on the proposed copayment element was supplied.

Committee on Medical Defense and Insurance ... Received as informative the report of the Committee stating that the professional liability insurance program and the activities of the Department of Liability Control continue to be a benefit to MSNJ.

Special Committee on Long-Range Planning and Development ...

(1) Delegates to Other States ... Approved the following recommendation:

> That the Society discontinue the practice of electing delegates and alternate delegates to other states, and that the selection of the individual to represent the Medical Society of New Jersey at the meetings of other state societies should be left to the discretion of the President. The Bylaws should be amended accordingly.

(2) Demographic Study of Membership ... Favored the proposal by Mr. Maressa to study demographic figures for future planning and recruitment activities for MSNJ.

State Board of Medical Examiners ...

(1) Report of Trustee Assigned to Attend April Meeting ... Received as informative a summary report from Doctor Costabile, the Trustee assigned to attend the State Board of Medical Examiners' meeting.

(2) Attendance of President-Elect at SBME Meeting ... Defeated a motion to rescind the previous action of the Board concerning the attendance of the President-Elect at the monthly meetings of the State Board of Medical Examiners. Hence, the President-Elect still is required to attend monthly meetings of the SBME.

New Business ...

(1) Mobile Intensive Care Unit Programs ... Directed that the appropriate authorities be notified of MSNJ's support for proper funding of mobile intensive care units.

2) Coalition for Public Health Priority Funding ... Agreed that the State Department of Health should be encouraged to increase the current level of funding for public health activities by local boards of health from $.25 to $1.00.

3) Letter to Nonparticipating Physicians from Blue Shield ... Directed that a communication be sent to Blue Shield indicating the efforts being taken by physicians to provide health care to the unemployed, and requested a response to the question as to what is being done to provide health insurance coverage to the unemployed.

Retiring Members of the Board ... Expressed appreciation to Doctor Garrison, Goracci, and Robins on their retirement from the Board of Trustees.

Trustees' Minutes May 2, 1983

A reorganization meeting of the Board of Trustees was held on May 2, 1983, at Resorts International Hotel and Casino, Atlantic City. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Reorganization ...

(1) Introduction of New Members ... Welcomed the newly elected members of the Board of Trustees: Joel S. Cherashore, M.D., of the First District, and John J. Pastore, M.D., of the Fifth District.

(2) Election of Chairman ... Elected Douglas M. Costabile, M.D., as Chairman.

(3) Meeting Schedule for 1983-1984 ... Voted to continue the practice of meeting regularly at 10:00 A.M. on the third Sunday of each month at MSNJ headquarters.

Standing Committee on Finance and Budget ... Reappointed Frank Campo, M.D., to serve a three-year term on the Standing Committee on Finance and Budget.

Old Business ...

(1) S-566—Licensing and Regulation of Athletic Trainers ... Voted to postpone final decision on this legislation until the June meeting and to maintain active opposition on **S-566.**

(2) Copayment Under Medicaid ... Defeated a motion to refer this issue to the

***The Journal* of the Medical Society of New Jersey**

announces the publication of the

WILLIAM CARLOS WILLIAMS COMMEMORATIVE ISSUE

September, 1983

Honoring the 100th anniversary of the birth of New Jersey's prize-winning poet and physician. Included in this handsomely illustrated, full-color issue will be original articles by persons close to William Carlos Williams, artwork from his social and intellectual circle, and samples of his finest writings.

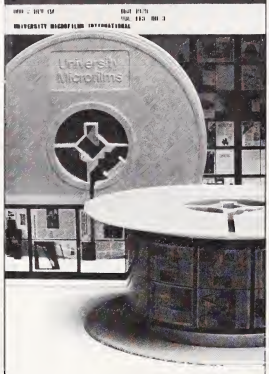
Copies of this special issue are available by sending $5.00 for each (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648. All members of MSNJ will receive one copy of this issue.

Please send a copy of the **William Carlos Williams Commemorative Issue** to:

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Committee on Medicaid. Instructed the MSNJ petition the Governor not to ad the economic burden of copayment un der Medicaid for indigent patients.

New Business . . .

(1) Referrals from 1983 House of Dele gates . . .

(a) Direct Candidacy for Elective Offic —Substitute Resolution #5 . . . Referrec the following substitute resolution to the Special Committee on Long-Range Planning and Development for study and report:

Resolved, that the Board of Trustees of the Medical Society of New Jersey seeks advice concerning alternate methods of carrying out the nomination and election procedures for officers and trustees. The Board of Trustees shall report its findings and conclusions to the 1984 House of Delegates.

(b) Proposed Revisions to the Joint Commission on Accreditation of Hospitals—Resolution #11 . . . Referred the following resolution to the AMA Delegation with the understanding that MSNJ's position to preserve the preeminence of physician control of hospital staff management and medical policies within the hospital structure will be upheld:

Resolved, that the Medical Society of New Jersey instructs its AMA delegation to oppose strongly the implementation of these proposed changes by the Joint Commission on Accreditation of Hospitals because they would lead to a decrease in the quality of care for future hospital patients.

(c) Ad Hoc Committee on Presentation of MSNJ DRG Position . . . Requested a written report on the progress of the DRG Committee, if possible, for the June meeting.

(d) Blue Shield Service Benefits . . . Filed the request for clarification regarding the difference in costs of the present group MSNJ Blue Cross/Blue Shield coverage versus nongroup MSNJ Blue Cross/Blue Shield coverage and noted that the information will be published in July through the Committee on Medical Defense and Insurance.

(e) Professional Review Organization Interference in Medical Judgment—Resolution #12 . . . Referred the following resolution to the executive staff of MSNJ for the development of a case report file to be reviewed by the Executive Committee:

Resolved, that the Board of Trustees of the Medical Society of New Jersey monitors the development of PRO under current federal and state laws, and establishes an ad hoc

mmittee to act as a liaison with the appriate PRO, in order to prevent unsonable interference with good medical ctice and insure physician involvement in review process; and be it further

Resolved, that the Medical Society of New rsey establishes a central reporting system ereby those cases in which PRO activities versely affect patient care can be reported d collated.

Mandatory Jury Service—Substitute esolution #18 . . . Referred the following substitute resolution to the President r appointment of an ad hoc committee:

Resolved, that the Medical Society of New rsey recognizes the civic duty of its members to serve as jurors; and be it further

Resolved, that the Society creates an ad hoc mmittee to advise those advocating change jury lists how to utilize physician jurors in fashion that would not disrupt the provision patient care.

Toxic Waste Disposal—Substitute esolution #6 . . . Directed that the following substitute resolution be referred the State Department of Environmental Protection and the news media:

Resolved, that the Medical Society of New rsey promptly advises the appropriate New rsey state agencies and New Jersey industry investigate and institute practical means to ispose of toxic waste; and be it further

Resolved, that the Medical Society of New rsey petitions state authorities to enforce trictly current laws regarding the disposal of xic materials and the dumping of hazardous astes in order to avoid further environmental pollution and its consequent public health azard.

Generic Substitution—Resolution #14 . . . Referred the following resolution to the Council on Medical Services for study and report:

Resolved, that the law be amended to provide that since patients are allowed to demand the generic substitution, the state of New Jersey be held responsible for the consequences of the substitution.

Drug Prices—Resolution #15 . . . Referred the following resolution to the Council on Medical Services for study and report:

Resolved, that the Medical Society of New Jersey petitions the pharmaceutical industry to keep their brand name drug prices within reasonable bounds, so that the physician effectively can prescribe them.

Dispensing of Generic or Brand Name Drugs—Resolution #16 . . . Referred the following resolution to the Council on Medical Services for study and report:

Resolved, that the law be changed to allow the patient and the pharmacist to decide whether or not generic or brand name drugs will be dispensed. This will relieve the doctor of legal responsibility for something he no longer can control.

(2) Medical Inter-Insurance Exchange of New Jersey . . .

(a) Report on Activities . . . Received copies of the 1982 Annual Report of the Exchange and a special report on the activities of the New Jersey State Medical Underwriters, Inc. Noted the following information from Doctor Todd: (1) despite increased competition, enrollment has increased; (2) insurance rates on the average have risen less than 3% per year since 1976, when the company was formed; (3) the frequency of cases per insured has been climbing; and (4) a special Department of Risk Prevention was established and will work with the Risk Prevention Committee of the Underwriter.

(b) Appointments to the Board of Directors . . . Approved Doctor Todd's reappointment to the Board of Directors of the Underwriter for a three-year term.

(3) Assembly Bill 2096 . . . Reaffirmed position of active opposition to this legislation that would establish a cost control board for the purpose of determining the applicability of a fee schedule for treatment under personal injury protection coverage and opposed any legislation that would impose a fixed fee schedule.

(4) Appointment of Students to MSNJ Councils and Committees . . . Carried the motion to have the President appoint members of MSNJ Student Association to serve on various councils and committees.

Committee on Annual Meeting . . . Noted that perhaps a poll could be taken of the 1983 delegates of their satisfaction with the current three-day annual meeting or the former four-day annual meeting.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D. President

Health professionals have good reason to be concerned about AIDS (Acquired Immune Deficiency Syndrome). Every day there are reports of new victims of this puzzling, deadly malady. Evidence is mounting, unfortunately, that AIDS is spreading beyond the limited population groups initially at risk—male homosexuals, intravenous drug abusers, Haitains, and hemophiliacs.

Until we identify the cause, almost certainly a transmissable agent, and find a cure, the danger to patients, their families, ourselves, and our colleagues cannot be dismissed. But there is no reason for panic or foolish fright. AIDS is not highly contagious. You do not get the disease by shaking hands with someone.

At University Hospital on our Newark campus, more than 35 cases of AIDS have been cared for without any of the staff becoming infected. We followed the special guidelines of the Centers for Disease Control which require isolating AIDS patients and taking other precautions like those used for contagious diseases.

Dispelling rumors and alleviating unjustified fears about this mysterious disease is one objective of a bill that would appropriate $75,000 to establish an AIDS Task Force Center on our Newark campus. By the time these notes get into print, the bill, which passed the Assembly without a dissenting vote, may have been approved by the state Senate and signed by Governor Kean. The sooner we get such a center in operation, the more quickly we can relieve New Jerseyans of the real threat and the imaginary fears of this new disease.

A major step in conquering AIDS would be the establishment of a special immunological laboratory on our Newark campus. New Jersey Health Commissioner, J. Richard Goldstein, M.D., cited the need for such a laboratory in recent testimony before the Legislature's Joint Appropriations Committee; he estimated the cost at $500,000.

In that connection, the sentiment expressed by *The New York Times* editorial on Sunday, May 15, 1983, entitled "The Scourge of a New Disease," is appropriate: "the National Institutes of Health . . . has done little to mobilize biomedical researchers, despite the high theoretical interest of AIDS, and was slow to find research in the field . . . the victims face a protracted and expensive illness with no certain outcome. They deserve more compassion from their Government and more resources for the sustained treatment and surveillance that might save them and others."

UMDNJ now is making available to New Jersey ophthalmologists a new advance in high technology for eye disease—the YAG (Neodymum Yttrium, Aluminum, Garnet) Laser. The YAG Laser is an instrument which transforms energy (light) into a mechanical force

which will alter optical tissues.

The machine currently is approved for a limited number of its many possible uses. These include posterior capsulotomy, anterior capsulotomy, resolution of pupillary blocks, second membranes, vitreous traction bans, and resolution of synechia. For treatment of secondary membranes and thickened posterior capsules, the advantages of the YAG include outpatient treatment, no anesthesia, no risk of infection, decreased medical costs, and immediate visual rehabilitation. The procedure, which is painless, generally takes 5 to 15 minutes.

Donations made through the Lions Club made possible the purchase of the $100,000 YAG system, which is located at the Eye Institute in United Hospitals, Newark. Applications for certification courses in use of the investigational equipment may be made by contacting the Eye Institute at (201) 268-8000.

The new chief executive officer of University Hospital, the UMDNJ-owned teaching hospital in Newark, is Leonard Lopez, of Guttenberg. Mr. Lopez, who is leaving a vice-presidency at Memorial Sloan-Kettering Cancer Center, is an authority on advanced technological systems needed for modern teaching hospitals. He has lectured around the world on hospital finance, computer systems, marketing, and capital equipment acquisitions. Mr. Lopez has a master's degree in health administration and a bachelor's degree in business administration, both from Washington University School of Medicine in St. Louis. He is a certified nuclear medical technologist.

Only one graduate student in the entire United States can receive the Procter and Gamble Fellowship Award as the one showing the most promise for a future career in toxicology. We are pleased that this year's award went to one of our students, Laurie Basting. She is in the second year of the four-year Joint Graduate Program in Toxicology conducted by UMDNJ-Rutgers Medical School and Rutgers University. Ms. Basting, whose husband, Greg, is a third-year medical student at UMDNJ-Rutgers Medical School, will receive tuition, fees, book expenses, and stipend.

New Members

The Journal would like to welcome these new members to the Medical Society of New Jersey.

Bergen County

William K. Boss, M.D., Tenafly
Ciro J. Carafa, M.D., Lodi
James R. Cole, M.D., Englewood
Myles E. Dotto, M.D., Woodcliff Lake
Dean F. Davies, M.D., Englewood
Sheldon Burt Eisenberg, M.D., Westwood
Theodore Falk, M.D., Teaneck
Joseph Giangola, M.D., River Edge
Dana L. Heikes, M.D., Westwood
Charles A. Herbstman, M.D., Teaneck
Alfredo S. Masullo, M.D., Hackensack
Eileen M. O'Connor, M.D., Fort Lee
Virginia F. Pellicci, M.D., Westwood
Jeffrey A. Rapaport, M.D., Fort Lee
Mitchell H. Rubin, M.D., Wyckoff
Michael J. Sternschein, M.D., Ridgewood
Dean H. Wasserman, M.D., Hackensack
Stephen N. Zoretic, M.D., Westwood

Burlington County

Thomas E. Bell, M.D., Marlton
Donald L. Clark, M.D., Moorestown
Stephanie Flicker, M.D., Browns Mills
Philip H. Varner, Jr., D.O., Mount Laurel

Camden County

Scott D. Gleditsch, M.D., Camden
Andrew L. Kousoulis, M.D., Haddonfield
Vincent E. Pierce, Jr., M.D., Camden
Henry Smergel, M.D., Haddonfield

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Marcia L. Comstock, M.D., Short Hills
Moses D. Elam, M.D., East Orange
Foun-Chung Fan, M.D., Newark
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Jose F.J. Leyson, M.D., East Orange
Charulata Patel, M.D., Bloomfield
Richard L. Siegel, M.D., Newark

Gloucester County

Anthony R. Giorgio, M.D., Woodbury
David A. Laskin, M.D., Woodbury

Hudson County

Mark A. Filippone, M.D., Wallington

Hunterdon County

Elisa T. Dulay, M.D., Whitehouse Station
Victor C. Dulay, M.D., Whitehouse Station

Mercer County

Belen P. Flores, M.D., Trenton
Steven Levenberg, M.D., Pennington
Michael J. Orlosky, M.D., Belle Mead
Brad S. Rogers, M.D., Trenton

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Laurence S. Chaise, M.D., Matawan
Lilia Flores-Bunales, M.D., Dunellen
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Kusum Kapoor, M.D., Somerset
Razia Q. Matin, M.D., East Brunswick
Gregory J. Palermo, M.D., Edison
Kamal B. Patel, M.D., Piscataway
Chenna G.S. Reddy, M.D., Somerset
Bhudev Sharma, M.D., Edison
Richard A. Snepar, M.D., Highland Park
John M. Weisenreider, M.D., South Plainfield

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Cary I. Skolnick, M.D., Freehold
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Joseph F. Guerrier, M.D., Hillside
Martin C. Hyman, M.D., Union
Jayesh G. Kanuga, M.D., Linden
Edward Mauceri, M.D., Summit
Steven J. Rosenthal, M.D., Springfield
Mitchell A. Schuman, M.D., Springfield

Warren County

John M. Brown, M.D., Phillipsburg
Che-Yi Chang, M.D., Phillipsburg
Pablito S. Luz, M.D., Phillipsburg

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Robert M. Klein, M.D., 5959 Delafield Ave., Riverdale, NY 10471. New York Medical College 1976. Subspecialty, pediatrics. Board certified, pediatrics; board eligible, immunology/allergy. Single or multispecialty group, partnership, solo, institutional. Available July 1984.

ANESTHESIOLOGY—Vithal D. Kardani, M.D., 408 Elkin Residence, 5501 North

11th St., Philadelphia, PA 19141. Shah Medical School (India) 1973. Board eligible. Group or partnership. Available.

Bharati Mistry, M.D., 74-26 45th Ave., Elmhurst, New York, NY 11373. T.N. Medical (India) 1972. Board eligible. Group, partnership, solo. Available.

Robert Sackheim, M.D., 200 Carmen Ave., 2B, East Meadow, NY 11554. Guadalajara (Mexico) 1979. Group, fee for service, solo. Available October 1983.

ARDIOLOGY—Amarjeet Singh, M.D., 5579 Glen Hill Dr., Bethel Park, PA 15102. Patiala (India) 1971. Also, general internal medicine. Board certified (IM). Group, partnership, solo, hospital-based. Available.

)ERMATOLOGY—Fred S. Gurtman, M.D., 3760 West Calhoun Pkwy., Minneapolis, MN 55410. Georgetown University (1974). Board certified. Group, partnership, solo. Available.

FAMILY MEDICINE—William J. Rayner, M.D., 616A Country Club Pkwy., Mt. Laurel, NJ 08054. New York Medical College 1975. Board certified. Group. Available.

David M. Horowitz, M.D., 2201 42nd St., NW, Apt. 103, Washington, DC 20007. NYU 1978. Also, general internal medicine. Board certified. Group or partnership. Available.

Khaja Naseeruddin, M.D., 409 North Broadway, Apt. 4S, Yonkers, NY 10701. Osmania (India) 1971. Board eligible. Group, partnership, solo. Available.

GASTROENTEROLOGY—N.P. Narayana, M.D., 31 Minebrook Rd., Apt. 169-B, Edison, NJ 08820. Mysore (India) 1971. Also, general internal medicine. Board certified (IM). Partnership, solo, group. Available.

Michael F. Fina, M.D., 633 Hertford Rd., Winston-Salem, NC 27104. New York Medical 1975. Board certified. Solo (primarily), group or partnership, second choice. Available.

Kailash Chand Singhvi, M.D., 240 Willoughby St., Apt. 10-C, Brooklyn, NY 11201. S.N. Medical College (India) 1977. Also, general internal medicine. Board eligible (IM). Group or solo. Available.

INTERNAL MEDICINE—Joseph S. Tan, M.D., 3221 Bloomfield Lane, #505, Auburn Heights, MI 48057. University of Santo Tomas (Philippines) 1975. Also, gastroenterology. Board certified. Partnership, group, solo. Available.

Helen Feit, M.D., 7-J Drummond, Rocky Hill, CT 06067. SUNY-Buffalo 1980. Board eligible. Salaried position—OPD, clinic, house physician. Available.

Maureen M. Kelleher, M.D., 85 Fourth Ave., Apt. 7-C, New York, NY 10003. Harvard 1978. Board eligible. Group. Available.

Arvind Mehta, M.D., 805 North Hanover St., Anaheim, CA 92801. University of Bombay (India) 1975. Subspecialty, nephrology. Solo, partnership, group. Available January 1984.

***The Journal* of the Medical Society of New Jersey**

announces the publication of the

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September, 1983

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Amarjeet Singh, M.D., 5579 Glen Hill Dr., Bethel Park, PA 15102. Patiala (India) 1971. Subspecialty, cardiology. Board certified. Group, partnership, solo, hospital-based. Available.

Kailash Chand Singhvi, M.D., 240 Willoughby St., Apt. 10-C, Brooklyn, NY 11201. S.N. Medical College (India) 1977. Subspecialty, gastroenterology. Board eligible. Group or solo. Available.

David M. Horowitz, M.D., 2201 42nd St., NW, Apt. 103, Washington, DC 20007. NYU 1978. Special interest, primary care. Board certified (FM). Group or partnership. Available.

Zakia R. Subhani, M.D., 85 Grant Ave., Colonia, NJ 07067. Liaquat (Pakistan) 1966. Board eligible. Any type practice. Available.

Mircea Cornesco, M.D., 415 E. 64th St., 1J, New York, NY 10021. Inst. of Medicine (Rumania) 1952. Group, partnership, solo. Available.

Carolyn Ann Rosenberg, M.D., 15704 27th Ave., North, Plymouth, MN 55441. Baylor College of Medicine 1978. Board certified. Group, associate, clinical setting. Available.

Walter H. Sturm, M.D., 140 Hampton Place, Staten Island, NY 10309. SUNY-Downstate 1979. Board eligible. Group or partnership. Available.

OBSTETRICS/GYNECOLOGY—Kyung S. Cha, M.D., 240 Willoughby St., 6G, Brooklyn, NY 11201. Korea University 1973. Board eligible. Group, partnership, solo. Available.

Judd Goodman, M.D., 4919 Laurel Canyon Blvd., Apt. 15, North Hollywood, CA 91607. Baylor 1974. Board eligible. Solo or group, preferably in NY metropolitan area. Available.

OPHTHALMOLOGY—Michael Hostovsky, M.D., 4100 West 36th St., Minneapolis, MN 55416. Hadassah (Israel) 1972. Also, neuro-ophthalmology. Board eligible. Single or multispecialty group. Available.

Tariq Saeed, M.D., 6906 Spourse Ct., Springfield, VA 22153. Liaquat College (Pakistan) 1968. Board eligible. Group, partnership, solo. Available.

OTOLARYNGOLOGY—Richard Schiffman, M.D., 2717 East 28th St., Brooklyn, NY 11235. Tufts 1977. Board eligible. Partnership or group. Available.

PATHOLOGY—Siamak Shokri-Tabibzadeh, M.D., Montefiore Hospital and Medical Center, 111 E. 210th St., Bronx, NY 10467. Tehran (Iran) 1977. Academic institution. Available.

Marvin N. Solomon, M.D., 3 Sutliff Ave., Vineland, NJ 08360. Berne (Switzerland) 1937. Special interest in anatomic and forensic. Board certified (PA); board eligible (forensic). Hospital staff, locum tenens. Available.

Pushpa Gupta, M.D., 100-C Thorndale Dr., Dayton, OH 45429. S.N. Medical College (India) 1971. Any type practice. Available.

PEDIATRICS—Steven Lewis Perrick, M.D., 17 Paerdegat 11 St., Brooklyn, NY 11236.

SUNY-Downstate 1980. Board eligible. Partnership, solo, group. Available.

Harvey A. Hirsch, M.D., 137-03 70th Rd., Flushing, NY 11367. Guadalajara (Mexico) 1978. Associate, group, partnership, HMO. Available.

Robert M. Klein, M.D., 5959 Delafield Ave., Riverdale, NY 10471. New York Medical College 1976. Board certified; board eligible, allergy/immunology. Multi-specialty group, partnership, institutional. Available July 1984.

Frantz Emmanuel Brea, M.D., 89-17 189th St., Hollis, NY 11423. University of Haiti 1971. Subspecialty, neonatology. Board certified. Group, partnership, institutional, solo. Available.

Kothari Purnima, M.D., 950 49th St., Apt. 8-F, Brooklyn, NY 11219. Grant (India) 1975. Board eligible. Group. Available.

RADIOLOGY (DIAGNOSTIC)—A. Rama Subramaniam, M.D., 186 Ellery Ave., P.O. Box 6189, Newark, NJ 07106. Stanley Medical College (India) 1964. Special interest, nuclear medicine. Solo, group, partnership, academic, hospital-based practice. Available.

SURGERY, GENERAL—Carlos A. Ferrari, M.D., 741 E. Tuscarawas, Barberton, OH 44203. Univ. National of Cordoba (Argentina) 1972. Board certified. Solo, small group, partnership. Available August 1983.

Matthew K.Y. Mo, M.D., 38123 Jamestown Dr., Sterling Heights, MI 48077. China Medical (Taiwan) 1974. Also, vascular surgery. Board eligible. Any type practice. Available.

Kothari Mayur, M.D, 950 49th St., Apt. 8-F, Brooklyn, NY 11219. Addisababa (Africa) 1974. Also, vascular surgery. Board eligible. Group. Available.

Jayesh R. Modi, M.D., 740 N. Bruns La., Springfield, IL 62702. Surat (India) 1974. Also, vascular surgery. Board eligible. Partnership or solo. Available.

SURGERY, VASCULAR—John P. Hubert, Jr., M.D., 33 Viking Village, N.W., Rochester, MN 55901. Minnesota 1975. Board certified. Private practice or single specialty in small group. Available.

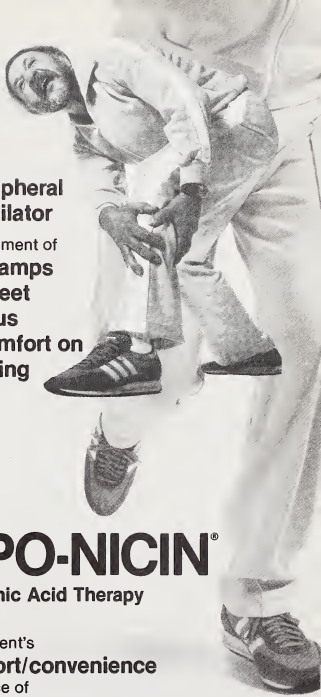
Matthew K.Y. Mo, M.D., 38123 Jamestown Dr., Sterling Heights, MI 48077. China Medical (Taiwan) 1974. Also, general surgery. Board eligible. Any type practice. Available.

Kothari Mayur, M.D, 950 49th St., Apt. 8-F, Brooklyn, NY 11219. Addisababa (Africa) 1974. Also, general surgery. Board eligible. Group. Available.

Jayesh R. Modi, M.D., 740 N. Bruns La., Springfield, IL 62702. Surat (India) 1974. Also, general surgery. Board eligible. Partnership or solo. Available.

UROLOGY—V.P. Nagarajan, M.D., 61 Maple Ct., Apt. 4, Snyder, NY 14226. Tirunelvel (India) 1973. Solo, group, partnership. Available.

Gary Neal Dunetz, M.D., 310 LaGrange St., Chestnut Hill, MA 02167. 77. Group, partnership, multi-speciality group. Available July 1984.



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JOSEPH H. KLER, M.D., New Brunswick

MICROSCOPY

Anthony van Leeuwenhoek (1632-1723) used the simple microscope based on a single lens ground with such delicacy and perfection that it could magnify to nearly 200 times. The lenses were tiny and short-focus, some being no larger than the head of a pin. In his lifetime, he ground a total of 419 lenses, many of which were focused on some permanently mounted object. Van Leeuwenhoek sent 26 of his tiny microscopes to the Royal Society of England so that members could see for themselves.



Leeuwenhoek
Netherlands, 1937

Leeuwenhoek sent 375 communications to the Royal Society and 27 to the French Academy of Science. He was elected member of the Royal Society and of the French Academy. His discoveries were dramatic enough to make him world famous. The Dutch East India Company sent van Leeuwenhoek Asian insects to put under his lenses, and the Queen of England and Peter the Great of Russia paid him visits. In 1677, he described protozoa and, in 1683, van Leeuwenhoek made his most remarkable discovery when he described bacteria. No one else was to see bacteria for over a century. Anthony van Leeuwenhoek truly is the father of protozoology and microscopy.

DIGESTIVE PROCESSES

Franciscus Sylvius (1614-1672) was born in Hanau, Germany, of Dutch parentage. He received his medical degree from Basel, Switzerland, in 1637. His chief interest was "alchemy" and he did not believe in the pythagorian belief that the health of the body depended upon the relative proportion of the four "humors" (blood, pH, black bile, and yellow bile). He viewed the body as Paracelsus did, i.e. as a balance of acid and base. Sylvius regarded digestion as a process of fermentation by saliva and pancreatic juice. His contemporary, Borelli, followed Descartes in viewing the body as a mechanical device but Sylvius viewed it as a chemical device. Sylvius was an excellent teacher with a creative mind. His work may be considered as the foundation of modern gastroenterology.



Sylvius
Netherlands, 1937

LETTER TO THE EDITOR

DRG—The Growing Impact on the Way We Practice

May 10, 1983

Dear Doctor Krosnick:

Diagnosis related groupings are designed financially to encourage shorter hospital stays for patients. Such an outcome requires more rapid diagnostic studies, quicker implementation of therapy, a new manner of obtaining consultation, improved social services, more immediate physical therapy, and altered related necessities. In a teaching institution, this accelerated process requires a closer liaison between attending physicians for improved communication regarding the patient in question.

To meet this challenge, the volume of paper work upon admission must be lessened to ensure earlier house staff access to the patient. This best is accomplished by having teams of house staff members examine the patient; by developing a plan after assessment; by drawing appropriate blood samples; and by developing x-ray studies on the day of admission. In return, the laboratory and x-ray reports must be on the charts by the time the patient reaches the assigned floor. Nurses on the floor will have to accelerate the process further, leaving much of the implementation of therapy to a skeleton night crew. Therefore, the night nurses and auxiliary staff will have to be augmented. Consequently, in order to provide the necessary preps for special intestinal and other studies, the hurried manipulation, and the rapid delivery of the patient from one area to another, coupled with a no-nonsense approach, affords little time for idle chatter between patient-roommates. Nurses and assistants will have to write fewer notes and be ever-more present at the bedside of patients. Nursing seminars and house staff conferences should be held to a minimum. Laboratory and x-ray tests must have a shorter turnover time so that the doctor's plan for the patient can be fulfilled. No longer can the patient's weary bones and post-illness myasthenia be a concern to the hospital staff. Also, social and psychiatric problems will have to be handled at a later time and in an outpatient manner. Followup reports to the house staff must be determined at a later date by communicating with the referring physician. Consulting physicians will have to be called in earlier, even before the data base is completed. Then, these specialists must respond immediately.

The rush system of DRG is a necessity for all of us. If it is to work, we must change our manner of practice. The quality of time with each patient must be more intense, less priestly, and more scientific. More people will "paw" the patient in a time shorter than ever anticipated.

What is the net result of such an endeavor? Much of the fat is removed from the system. Coffee breaks must be fewer in number, paperwork must be shortened, and doctors, nurses, and all hospital personnel must communicate more closely to improve coordination of a given plan. The name of the game is rapid patient turnover without affecting the quality of care. As DRGs progress, delivery of the patient would be better handled on a conveyor belt, stopping momentarily along the way to obtain necessary studies. By necessity, we shall become so efficient that robots will have to replace more and more personnel along the conveyor system.

Let us join forces and share our DRG experiences so that the financially strapped medical system can work. Hospitals then will become as efficient as the Japanese auto worker on an assembly line, producing a superb product at a reduced cost. To make the system work, we will need more administrators—a necessary byproduct with which we all must live.

Leon G. Smith, M.D.

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NJ

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, The Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Sept.

24-25 Advances in Pain Management
8 a.m.-5 p.m.—Resorts International, Atlantic City
(UMDNJ and AMNJ)

MEDICINE

Sept.

13 Newest Guidelines on Step Care Therapy in Hypertension
9-10 a.m.—Holy Name Hospital, Teaneck
(Holy Name Hospital and AMNJ)

14 New Concepts of Pain and Pain Control for the Ambulatory Patient
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

14 Abuse of Tranquilizers

21 Current Concepts in the Therapy Common Arthritic Conditions

28 Male Sexual Dysfunction
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

20 Pulmonary Emboli
9-10 a.m.—Holy Name Hospital, Teaneck
(Holy Name Hospital and AMNJ)

28 Nutrition
9:30 a.m.-4:30 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

29 Irritable Bowel Syndrome and Other Functionally Related Gastrointestinal Diseases
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

NEUROLOGY/PSYCHIATRY

Aug.

1 Psychiatric Case Conference
8 7:30-11:30 a.m.—Trenton Psychiatric
15 Hospital
22 *(Trenton Psychiatric Hospital and*
29 *AMNJ)*

3 Child Psychiatry Case Conference
10 10 a.m.-12 noon—Trenton Psychiatric
17 Hospital
24 *(Trenton Psychiatric Hospital and*
31 *AMNJ)*

4 Hypnosis: Update on Diagnosis and Treatment Issues

11 Mood Disorders in Children and Adolescents

18 Creative Arts as Therapy
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

Sept.

1 Morbid Obesity: Update of Causes and Fears

8 Lateral Dominance in Psychiatry

15 Psychodrama as Therapy
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

5 Psychiatric Case Conferences
12 7:30-11:30 a.m.—Trenton Psychiatric
19 Hospital
26 *(Trenton Psychiatric Hospital and*
AMNJ)

7 The Unique Role of Creative Arts: Therapies and Therapists
9:30 a.m.-4:45 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

PATHOLOGY

Sept.

21 Pathology Slide Seminar/New Procedure Update
7-9 p.m.—Hyatt House, Cherry Hill
(South Jersey Pathology Society and AMNJ)

22 Comparative Neoplasia

29 Tumor Growth Factors
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

PEDIATRICS

Sept.

15 Neonatal Resuscitation and Stabilization Workshop
8 a.m.-4 p.m.—Children's Hospital of NJ, Newark
(United Hospitals Medical Center, NJ Medical School, and AMNJ)

27 What's New in Pediatric Dermatology?
8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

RADIOLOGY

Sept.

15 Lymphoma of the Small and Large Bowel
7:30 p.m.—St. Barnabas Medical Center, Livingston
(Radiological Society of NJ and AMNJ)

21 Dinner Meeting
6:30 p.m.—The Manor, West Orange
(AMNJ)

24-25 Basic Echocardiography
9 a.m.-5 p.m.—Nassau Inn, Princeton
(The National Foundation for Non-invasive Diagnostics and AMNJ)

SURGERY

Aug.

3 Surgical Departmental Conferences
10 8:30-10 a.m.—Medical Educ. Bldg.
17 Rm. 108, Rutgers Medical School,
24 New Brunswick
31 *(UMDNJ)*

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastics, and Vascular Surgery)

Aug.

4 Vascular Conference Rounds

11 4-5 p.m.—Medical Educ. Bldg. Rm. 593, Rutgers Medical School, New Brunswick
(UMDNJ)

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 25-hour accredited seminar and workshop on the latest theories & techniques of manual and electro-acupuncture, applicable toward the 100-hour requirement for certification, will be given for licensed clinicians (with or without prior training) during the weekend of June 24-26, 1983 and again the weekend of September 23-25, 1983 at the Barbizon Plaza Hotel, New York City. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its official journal (published by Pergamon Press) the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital. Also eligible for AMA/CME credit. For information, contact Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I), NYC 10032. Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.

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OBITUARIES

Dr. John T. Bauer

At the grand age of 84, John Trexler Bauer, M.D., died on March 24, 1983. A graduate of Johns Hopkins Medical School, Maryland, in 1925, Dr. Bauer was affiliated with Burlington County Hospital, Mount Holly, during his lengthy career. Dr. Bauer was a member of our Burlington County component, a Diplomate of the American Board of Pathology, a Fellow of the American College of Pathology, and a member of the American Medical Association. In 1975, Dr. Bauer was a recipient of MSNJ's Golden Merit Award in recognition of his 50 years of medical practice.

Katherine T. Cingale

Katherine Trunzo Cingale, former Executive Director of the Passaic County Medical Society, died on March 1, 1983, at the age of 61. Born in Coalport, Pennsylvania, Mrs. Cingale lived in Paterson and Clifton. Mrs. Cingale served as Executive Director for the Passaic County Medical Society for 21 years. She was a member and trustee of the Dwight D. Eisenhower Library, Totowa.

Dr. Pedro A. Cuni

Word has just been received of the death of Pedro A. Cuni, M.D., a family practitioner from Kearny. Born in 1905, in Cuba, Dr. Cuni earned his medical degree from the University of Havana Medical School, Cuba, in 1928. Dr. Cuni completed an internship at West Hudson Hospital, Kearny, in 1968 and practiced privately in the area until his retirement in 1978. Dr. Cuni was a member of our Essex County component.

Dr. Anna Kara

At the untimely age of 59, Anna Kara, M.D., died on February 9, 1983. Dr. Kara earned her medical degree at the University of Montreal (Canada) in 1948. She was the director, physical medicine and rehabilitation, St. Clare's Hospital, Denville, and was affiliated with Cornell Hospital and New York Hospital, both in New York. Dr. Kara was a member of our Morris County component, a Diplomate of the American Board of Physical Medicine and Rehabilitation, and a Fellow of the American Academy of Physical Medicine and Rehabilitation.

Dr. John F. Lewis

John Francis Lewis, M.D., director of pediatrics at St. Mary's Hospital, Hoboken, died on April 18, 1983. Born in 1923, Dr. Lewis received a medical degree from New York University School of Medicine in 1946, and then practiced for 30 years at St. Mary's Hospital. Dr. Lewis was a member of our Hudson County component, a Diplomate of the American Board of Pediatrics, and a Fellow of the American Academy of Pediatrics.

Dr. David W. McCreight

David Wade McCreight, M.D., retired assistant clinical director and medical director of Marlboro Psychiatric Hospital, died on April 12, 1983. Born in 1906, Dr. McCreight received his medical degree from Ohio State Medical College in 1931. A retired member of our Monmouth County component, Dr. McCreight was a member of the American Medical Association, and a Fellow of the American Psychiatric Association. In addition to his work at Marlboro Psychiatric Hospital, Dr. McCreight was a member and vice-president of Monmouth County Hospital for Tuberculosis. Dr. McCreight was a recipient of MSNJ's Golden Merit Award in 1981.

Annette B. Nicholas

Annette B. Nicholas, Executive Secretary of the Mercer County Medical Society, died on March 25, 1983. Born in 1923 in Washington Crossing, Pennsylvania, Mrs. Nicholas lived most of her life in the Trenton area. She served as secretary to the Board of Directors of the Trenton Psychiatric Hospital and as secretary to the administrator of Helene Fuld Medical Center. For the past 24 years, Mrs. Nicholas worked for the Mercer County Medical Society.

Dr. Arthur D. Reinkraut

Word has been received of the death of Arthur David Reinkraut, M.D., on April 12, 1983. Born in 1912 in Vienna, Dr. Reinkraut earned a medical degree at the University of Vienna in 1937 and came to the United States in 1940. He was a family practitioner from 1945 to 1982. During his lengthy career, Dr. Reinkraut was affiliated with General Hospital, Passaic, and was a member of our Passaic County component.

Dr. Myron E. Tracht

Word has been received of the death of Myron Edward Tracht, M.D., in October, 1982. Born in 1928, Dr. Tracht earned a medical degree from the University of Chicago in 1955. Dr. Tracht was pathology laboratory director at United Hospitals, Newark. He was a Diplomate of the American Board of Pathology, a member of our Bergen County component and of the American Medical Association, and a Fellow of the American Society of Clinical Pathology.

Dr. Albert J. Zoretic

Albert James Zoretic, M.D., a retired member of our Bergen County component, died on March 23, 1983. Dr. Zoretic was born in 1918, and received his medical degree from Marquette University School of Medicine, Wisconsin, in 1950. Dr. Zoretic served as associate director of the department of surgery at Pascack Valley Hospital, Westwood, for 21 years before his retirement in 1980. Dr. Zoretic was a member of the American Medical Association, a Diplomate of the American Board of Surgery, and a Fellow of the American College of Surgeons.

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BOOK REVIEWS

Atlas of Mammography

John E. Martin, M.D. Baltimore, MD, Williams and Wilkins Company, 1982. Pp. 335.

With the high incidence of 1 out of 11 women developing carcinoma of the breast in her lifetime, a good book on mammography is welcome. John E. Martin, M.D., of the M.D. Anderson Hospital, a pioneer in the use of xeromammography, has written such a book.

This is an all-inclusive work in which blue-tinted reproductions of xeromammographs are used to illustrate the various diseases of the breast. Throughout the book ample illustrations of the pathology are correlated with the radiographic findings.

Of prime importance is the description of the indirect signs of malignancy, before the carcinoma is evident. The discussion and illustrations of malignant and benign calcifications is thorough and enlightening. The author stresses the importance of finding abnormal retroareolar mammary ducts and asymmetry of breast tissue that give the physician a clue as to the presence of a carcinoma.

The author abandons the wastebasket use of the term, "fibrocystic disease." He prefers that the radiologist be more specific, and use the terms: "cysts," "fibrosis," "chronic inflammation," "epithelial hyperplasia," "adenosis," and "sclerosing adenosis." He does not feel that "fibrocystic disease" is in fact a disease but is rather a benign process related to the involution of the breast.

Needle localization of nonpalpable lesions prior to surgery is well described and illustrated and will be of interest both to the radiologist and to the surgeon.

There is a very good discussion of the controversy concerning the possible radiation hazards of mammographic screening for the detection of early carcinoma. He confirms the low radiation risk of mammography and the significantly increased cure rate in finding small lesions by screening.

Atlas of Mammography is recommended strongly to radiologists and to other physicians interested in diseases of the breast. It will hone their ability to find early carcinomas so that more cures will be obtained.

Sidney Ketyer, M.D.

Essentials of Medical Ultrasound

M. H. Repacholi and D. A. Benwell (eds). Clifton, NJ, Humana Press, Inc., 1982. Pp. 330. Illustrated. ($44.50)

This complete and succinct monograph fills the needs for an intermediary text on the biomedical foundations of ultrasound diagnosis and therapy. It definitely has a place on the bookshelf of the physician who is responsible for the day-to-day management of ultrasonography.

From an introductory review of the physics of ultrasound, the discussion moves to measurement techniques and potential hazards. The section on applications is a synthesis of technical aspects, basic interpretative considerations, and an explanation of the importance of sonography in the diagnosis armamentarium. Therapeutic applications also are reviewed. The chapter on quality assurance explains the parameters governing the performance of the major components of various ultrasound imaging systems including Doppler and 2-D echography; experimental systems also are described.

The book includes an interesting chapter, describing how the clinician can evaluate existing standards and, if he wishes, devise his own. A well-chosen glossary provides descriptions of commonly used terms. With college physics and some calculus, the reader comes away with a firm grasp of the technical considerations involved.

Neil B. Horner

Infectious Diseases in Obstetrics and Gynecology, Second Edition

Giles R.G. Monif, M.D. Philadelphia, PA, J.B. Lippincott, 1982. Pp. 671. ($62.75)

This book is the second edition of the original version published in 1974. The text probably was the first comprehensive publication ever written dealing with infectious diseases of the pelvis, the pregnant woman, and the fetus.

Although it is a multiauthored text (19 contributors), the editing has been done skillfully, providing a uniform quality. The book is composed of four sections (general considerations, organisms, infections in the obstetric patient, and gynecologic infections) and an appendix dealing with miscellaneous infections in obstetrics and gynecology. Each chapter presents an outline of the topics to be discussed, which facilitates the reading dramatically. The list of selected references is excellent.

This undoubtedly is the most comprehensive, updated, easy-to-read, and complete treatise presently available that deals with infectious diseases in obstetrics and gynecology.

On the negative side, it is unfortunate that the overall excellence of the book has been tarnished somewhat by the use of black and white instead of color photographs. When dealing with lesions of the female genital tract, the differential diagnosis by simple visual examination is extremely important, and the use of color photography to illustrate them is a great help to the student.

This text is a must for anyone interested in the topic of infectious diseases in obstetrics and gynecology, and it is recommended highly by the reviewer as a complement to existing standard textbooks in obstetrics and gynecology.

Marco A. Pelosi, M.D.

Instructions for Patients

H. Winter Griffith, M.D. Philadelphia, PA, W. B. Saunders Company, 1982. Pp. 419. ($35)

This is the third edition of a very comprehensive set of printed instructions designed for distribution by the physician to the patient as an aid in understanding the condition being treated. Each topic (from abdominal pain to x-ray examination) gives general information, important points in treatment, and a guide as to when to call the office if the problem is not resolving.

The pages of this book and an office copying machine make over 260 patient information leaflets available. The sheets may be taken out and placed in a loose leaf binder, as the holes have been

punched out. The text has a section on various diets as well as a series of anatomic drawings. Such diagrams are useful in explaining a medical condition and may aid in informing the patient as to the extent of proposed surgery. Keeping a copy of the instructions given on the chart may document the effort made to keep the patient fully informed. In the legal climate of today, such a step is worthwhile.

As in any large undertaking, there are some errors. The problem of ABO incompatability during pregnancy is overstated and may cause needless anxiety to the patient. Likewise, suggesting to the person having painful or difficult sexual intercourse that she avoid cigarette smoking seems inappropriate.

Recommended for "those physicians in primary specialities who wish to foster patient awareness and participation in their health problems."

Gerard F. Hansen, M.D.

Medical Complications During Pregnancy

Gerard N. Burrow, M.D., and Thomas P. Ferris, M.D. Philadelphia, PA, W.B. Saunders Company, 1982. Pp. 583.

Two professors of internal medicine have assembled 27 academic physicians, including 6 obstetrician/gynecologists to provide 23 chapters that seem to cover every possible disease that might occur during pregnancy. This very comprehensive volume briefly mentions the more unusual diseases but exhaustively delves into all aspects of such commonly occurring conditions as hypertension, diabetes, and infection. Except for Doctor Ferris's management of "toxemia" which represents a departure from conventional obstetrical practice, there is very little controversial material. All of the information is presented systematically and logically for easy reference.

Assuming that practicing obstetricians have learned to moderate the advice of academics who have had limited contact with private outpatients, the diagnostic and therapeutic procedures detailed in this book can be read with discernment to comprehend the potential seriousness of certain medical complications of pregnancy. This complete reference book is highly recommended to any obstetrician who, despite the availability of superior medical consultation, bears the chief and ultimate responsibility during the major portion of pregnancy, labor, and puerperium.

Jerome Abrams, M.D.

Medical Word Finder, Third Edition

George Willeford, Jr., M.D. Englewood Cliffs, NJ, Prentice-Hall, Inc., 1983. Pp. 432.

Physicians and all medical support staff will find the *Medical Word Finder, Third Edition,* a valuable tool for spelling, pronounciation, and syllabication of uncommon and frequently used medical terms.

The book is neatly divided into ten sections, including a list of prefixes and suffixes, an alphabetical listing, a specialty listing, a list of abbreviations, and a list of commonly prescribed drugs.

This reference book, while complete and printed in an easy-to-read typeface, is no excuse for not owning a medical dictionary. *Medical Word Finder* should be used in conjunction with other reference materials—for an instant quick reference. *Medical Word Finder* is a one-stop source for spelling and syllabication.

Researchers, writers, and readers will be interested in this small-sized text, to facilitate writing and speaking. G.H.

1983 Year Book of Neurology and Neurosurgery

R.N. DeJong, M.D., R.D. Currier, M.D., O. Sugar, M.D., (eds). Chicago, IL, Year Book Medical Publishers, 1983. Pp. 478.

It is a delight to be able to go through and selectively read the excellent choice of succinct abstracts presented by the veteran editors in the *1983 Year Book of Neurology and Neurosurgery.* Best of all, their comments following most articles afford the reader, whether a specialist or a family physician, insight into the bias of a particular paper or how other authors consider the same problem. Often, cross references are given to afford the reader a broader view.

The subject index is quite complete and the selection of the papers, in general, offers a broad view of the field of neurology, neurosurgery, systemic disorders affecting the nervous system, and the medical and surgical thinking from 54 journals printed here and abroad.

DeJong's introduction is a most interesting historical background to current thinking. It sets the flavor for the rest of the book which should be in the library of every family physician, internist, and all of those whose work touches upon the nervous system.

Henry R. Liss, M.D.

Ultrasonography in Obstetrics and Gynecology

Peter W. Callen, M.D. Philadelphia, PA, W.B. Saunders Company, 1983. ($45)

The subject of this text is thoroughly and eruditely covered, as well as up to date. Dr. Callen asked not less than 35 persons, both radiologists and obstetricians, for contributions to this treatise; all are experts in their respective fields.

The first paragraph of the preface emphasizes that the book will go beyond the usual subjects, such as dating the age of the fetus or outlining a cystic ovarian mass. The text will describe in detail the "subtle abnormalities of almost every fetal organ system" and their relationship to prenatal diagnostic procedures.

The chapter entitled, "Ultrasound Evaluation of the Normal and Abnormal Fetal Neural Axis," especially is valuable since it takes in not only the gross deformities of the brain, such as hydrocephalus, microcephaly, and anencephaly, but it gives pictures of the failure of fusion of the spinal column such as in lumbar spine defects or spina bifida.

Noteworthy are the abnormalities of the placenta since not only conditions such as placenta previa and abruptio placentae are illustrated; the diagnosis of choriocarcinoma or hydatidiform mole likewise is possible by ultrasonography.

Ultrasound demonstration of uterine myomata has been known for some time. What is new is that conditions of failure of the Müllerian ducts causing congenital uterine malformations also are accessible to ultrasound diagnosis. Drs. Barry H. Gross and Peter W. Callen who wrote the chapter, "Ultrasound of the Uterus," point out that even disorders such as endometrial hyperplasia and adenomyosis may be diagnosed through ultrasonography; yet their differentiation from uterine malignancies often encounters difficulty in diagnosis. Other limitations of the procedure are the differential diagnosis between ectopic pregnancy and pyosalpinx or ovarian cyst.

This reviewer has not found any shortcomings of this book; it is very exhaustive. It might have been worthwhile to show illustrations of the B-scan ultrasonograph that is standard equipment in every hospital today, and the "portable" real-time machine that may be found in delivery rooms and obstetrical clinics as well as in many private

offices of obstetricians. In an overall perspective, Dr. Callen should be congratulated for collecting and editing such a valuable symposium; the book is highly recommended to obstetricians and radiologists alike.

Werner Steinberg, M.D.

Vascular Disorders of Childhood

Richard H. Dean, M.D., and James O'Neill, Jr. Philadelphia, PA, Lea & Febiger, 1983. Pp. 205. ($27.50)

The flyer that accompanies this book states that it is "the first text devoted solely to extracardiac vascular disorders in children." Whether or not this is strictly true, it's about time we had such a book. The fact that Dean has written 3 of the 13 chapters himself, and coauthored several of the others, gives the book a cohesive style and content with virtually no overlapping of material. It is almost falacious to entitle this book "disorders of childhood," because there are many sections of great importance to the adult cardiovascular surgeon, such as the embryological development of the vascular system, the consequent anomalies of the entire aorta, abdominal aorta, and venous system. The cardiovascular surgeon will be happy to find in one source descriptions of the many conditions which persist into adult life. Because many of these disorders are associated with hypertension, there is a thorough and well-written background on the experimental evidences which support the present concepts of the etiology of hypertension, not only those cases due to anomalies of the aorta, but also those related to primary renovascular hypertension.

Each section provides a succinct review of its topic, including the generally accepted therapies and anticipated results of surgical and nonsurgical treatments all without going into unnecessary detail.

The only omission that the authors might like to correct in their next edition is a description of the problems derived from vascular access procedures. Cardiovascular surgeons often have contact with the very young patients only to treat those disorders.

The chapters adequately are referenced, so that the interested reader may go elsewhere for more details. As it stands, the text is ideal for the practicing cardiovascular specialist. It is well illustrated, pleasingly presented, reasonably concise, and reasonably priced.

Victor Parsonnet, M.D.

The Woman Patient. Volume 3

Malkah T. Notman, M.D., and Carol C. Nadelson, M.D., (eds). New York, NY, Plenum Publishing Corporation, 1982. Pp. 314. ($24.50)

This book is the third by the same two editors. The focus of the series was on women's health care issues with a laudatory goal of encouraging the integration of new psychosocial insights and feminist-based cultural changes into health care planning, education, and practice. Volume 1 addressed sexual and reproductive aspects of women's health care. Volume 2 dealt with concepts of femininity and the life cycle. The current volume is subtitled, "Aggression, Adaptations, and Psychotherapy."

If the editors remained true to the original purpose of this series, this book might have made a significant contribution to the medical literature. Instead, the editors have retreated to preaching to the converted and have ostensibly addressed this volume to an audience of mental health care professionals and those interested in women's studies.

The writing, organization, and clarity of each chapter is variable. Better editing and summaries of the focus of each contribution would have been of benefit.

The current volume is organized into three sections. The first eight chapters are subsumed under the heading, "Aspects of Aggression and Violence." The initial chapter is more in the nature of an introduction to the book and represents an unsuccessful attempt to pull together very disparate material loosely relating to women as patients (psychotherapy or medical). The second chapter deals with aggression in women from a psychodynamic developmental perspective and makes the point that women are socialized to inhibit direct expression of aggression and its derivatives that are not in the service of others with resultant limitations in self-fulfillment and vulnerability to psychosocial distress. Vulnerability to physical distress is only implied. The remaining six chapters in this section are a potpourri of topics involving women and violence (either violence directed against women by others, by women towards others, or by women against themselves).

The second section, "Symptom Formation and Illustrative Symptoms," consists of six chapters. The two introductory theoretical chapters are of interest in their focus on the complex biological, psychosocial, and social determinants of illness, diagnosis, and treatment. The remaining four clinical chapters address such disparate topics as miscarriage, depression, the myofascial pain dysfunction syndrome, and alcohol abuse with varying success.

The final section, "Therapy," is comprised of four chapters. This is the weakest section of the book saved only by an interesting clinically based chapter on special issues for women in psychotherapy which demonstrates the importance of therapists repeatedly evaluating their own unconscious biases and assumptions about the role and nature of women.

A glimmer of what this book might have been is evident in several excellent chapters which should be of interest to the primary care physician. Elaine (Hilberman) Carmen's chapter, "Wife Abuse; Culture and Destiny," alerts the physician to the startling frequency and the medical and social ramifications of this problem. Fifty-six out of 60 women referred for psychiatric consultation from a general medical clinic were found to be previously unidentified victims of severe spouse abuse. Similarly, the chapter by Friedman and Cohen, "Emotional Reactions to the Miscarriage of a Consciously Desired Pregnancy," makes the physician aware of the often overlooked significant emotional sequelae of spontaneous abortion and recommends useful professional and self-help interventions. Other well-written chapters of interest to health care providers include: "The Painful Woman: Complaints, Symptoms, and Illness"; "Depression in Women: Epidemiology, Explanations, and Impact on the Family"; and "The Myofascial Pain Dysfunction Syndrome: An Unheeded Neuromuscular Disorder."

The book represents a lost opportunity for extending the base of knowledge of health care providers in their treatment of women patients. However, particular individual chapters will prove to be of interest to health care practitioners, mental health professionals of various levels of expertise, and those concerned with women's issues.

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1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis.* New York, NY, McGraw-Hill, 1969, Pp. 42-48.

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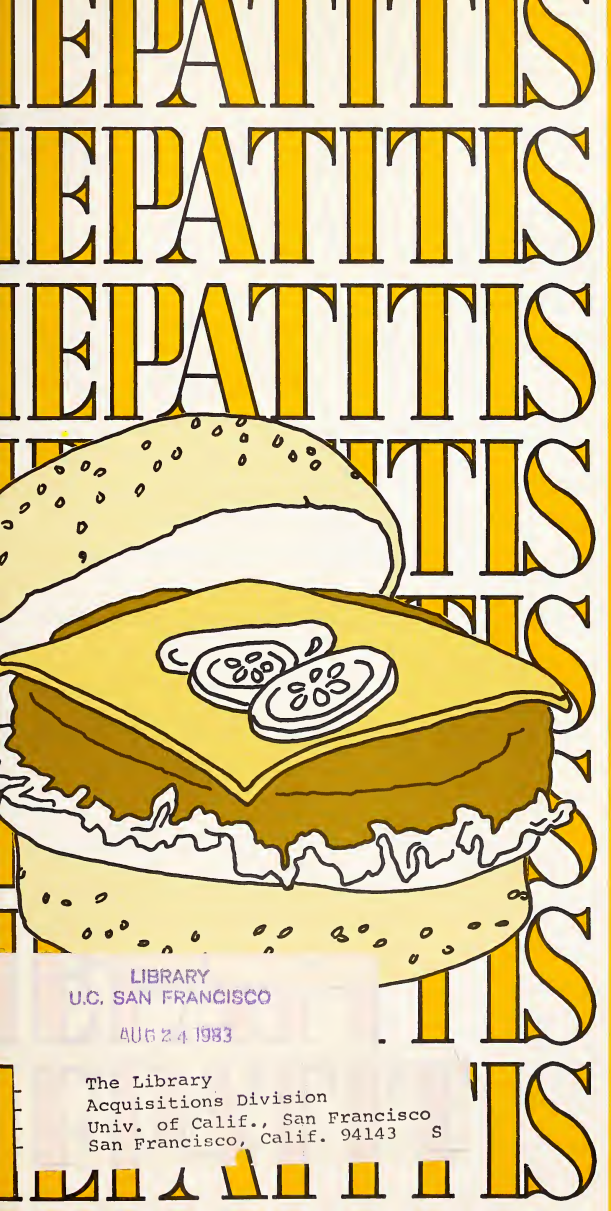
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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-5]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Brief Summary: Consult the package literature for prescribing information.

Indications and Usage Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *Staphylococcus aureus*. Pneumonia due to *Klebsiella* or *Pseudomonas* species is usually not treated with Ceclor.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication. Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS IN PENICILLIN-SENSITIVE PATIENTS. SERIOUS ACUTE REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, discontinue the drug. Serious allergic reactions in a patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the donor or recipient blood, a history of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because dose adjustment may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 10 times the human dose and wherein) gives three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three four, and two hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal—Diarrhea occurs in about 3.5 percent of patients and include diarrhea (1 in 10).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include multiform erythema (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 100 patients. Eosinophilia, serum-sickness-like reactions (erythema multiforme, skin eruptions associated with arthralgia, arthritis, or both) occur infrequently, and, frequently, fever have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. Anaphylaxis has been reported rarely. Serum sickness-like reactions appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 36 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Laboratory Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, thrombocytopenia, lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[041782R1]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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On The Cover: In 1979, the New Jersey Department of Health investigated a foodborne outbreak of hepatitis A. In this outbreak, 24 cases were traced to a diner where cheeseburgers were associated with the illness. Read the complete story on page 612. Cover illustration is by Claudia Teal.

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MEMBERSHIP NEWSLETTER

MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 2

ARTIFICIAL BLOOD

The artificial blood market in Japan easily should top $75 million a year, and the prospect for sales in the United States is a good deal higher. At least that is the hope of the Green Cross Corporation of Osaka, Japan, a leader in the development of artificial blood, and of its U.S. subsidiary, Alpha Therapeutic of Los Angeles.

Green Cross has been researching perfluorocarbon (PFC) for 15 years. The firm expects its artificial blood, dubbed FluosolDA, to win Japanese government approval later this year. It hopes that the Food and Drug Administration will agree to allow distribution by 1985 or 1986.

So far, Japanese scientists have administered Fluosol to 700 patients with no adverse effects. In the United States 50 Americans have been given dosages, mostly acute anemics who could not accept ordinary blood transfusions. Green Cross also is exploring possible applications in stroke and heart attack patients, as well as in cases of sickle-cell anemia.

"The market for the stuff is really fantastic," said PFC research pioneer Dr. Leland Clark. "It doesn't have blood types; it can be autoclaved so there's no danger of spreading disease, and you can store it indefinitely. If anything, the demand for artificial blood has been underestimated."

DRG WAIVER

The Federal District Court for the District of Columbia entered an order on May 19, 1983, that declared the Secretary of Health and Human Services failed to comply with 42 USC §1395 footnote (1976) (§222 (a) of Public Law No. 92-603) prior to implementation of the New Jersey experiment in prospective payment of Medicare providers as provided by law.

The Court further declared that the DHHS failed to comply with its own internal procedures for approving a waiver of Medicare reimbursement principles prior to the issuance of approval for the New Jersey waiver. The scope of relief to be granted will be decided at a further date. *Riverside General Hospital v Heckler et al.* C.A. No. 81-1501 (Federal District Court for the District of Columbia).

GOLDEN MERIT AWARDS

The Golden Merit Award of the Medical Society of New Jersey is one of the most prestigious awards that the Society grants to its members who have held the degree of doctor of medicine for 50 years.

A total of 96 physicians qualified for the award this year. A survey was made of the 37 recipients who attended the ceremony and the results are as follows: 20 liked the ceremony as it was presented; 1 preferred the ceremony in the House of Delegates; 1 preferred the ceremony at the Executive Offices; 1 wanted it separate from the Annual Meeting; and 14 had no reply.

UNKNOWN DRUGS

Use of nonprescribed drugs by adolescents results in frequent requests from concerned parents in detecting what type of drug they have confiscated from their children.

The New Jersey Department of Health, Division of Alcohol and Drug Abuse, has provided the names of three private laboratories that will perform this service for a fee that is determined by the extent of the testing needed to establish the drug identity.

The following were offered by the Department of Health as a possible source of service with no recommendation from the Department of Health: Psychiatric Diagnostic Laboratories of America, 1 Prospect Street, Summit, NJ 07901, (201) 522-7000; MetPath, Inc., One Malcolm Avenue, Teterboro, NJ 07608, (201) 393-5400; and Accutest Laboratories, 578 Livingston Avenue, North Brunswick, NJ 08902, (201) 249-7402.

The state labs will not handle the analysis unless it is offered through the police as a result of a crime.

RULES RENEWAL

The Division of Medical Assistance and Health Services is renewing two rules, *N.J.A.C. 10:49-2,* Availability of Program Policy Issuance, and *10:49-5,* Fair Hearings. Both rules are being readopted without any change in the text to comply with Executive Order

No. 66 (1978). Notice of the proposed readoption will appear in a subsequent issue of the *New Jersey Register.* Both subchapters were developed pursuant to federal regulations, which require manuals, newsletters, and bulletins be available and distributed to interested persons, and also allow for hearings for both recipients and providers who wish to contest state agency denials.

RETIRED LIVES RESERVE

The Medical Society of New Jersey recently has endorsed a new benefit plan for Society members called Retired Lives Reserve. This is the only tax-advantaged method available to continue group term life insurance after a physician retires. Group term life insurance almost always is terminated either at or shortly after retirement and if a physician dies after retirement (usually the case), the family is left without the group term life benefit. Retired Lives Reserve is an annual funding program accomplished during a physician's working lifetime to provide enough money at retirement to continue paying premiums on the group term policy until he dies. Retired Lives Reserve converts a terminable benefit into one that is guaranteed and permanent.

Retired Lives Reserve has four tax advantages:

1. The deposits placed in the reserve fund are tax deductible to the corporation.
2. The interest earnings on the reserve fund are not taxed as income to the physician.
3. The proceeds at death pass income tax free to the beneficiary.
4. If a spouse or trust is named the beneficiary, the proceeds avoid federal estate taxes.

This is only property afforded all four tax advantages by the internal revenue code. These tax advantages make Retired Lives Reserve plans particularly attractive for physicians. Because of the changes under the new Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), any benefits over $100,000 from qualified pension or profit-sharing plan now are subject to federal estate taxes and current tax rates could claim about half of the retirement plan(s) proceeds. Thus, if conventional life insurance is in a qualified retirement plan, the proceeds will be subject to federal estate tax erosion. This would not be the case with Retired Lives Reserve, where effective planning will avoid the federal estate tax on death benefits.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) also has imposed serious limitations on the annual contributions and ultimate payout benefits of qualified retirement plan. Restrictions also have been placed on so-called "top heavy" plans. These new statutory limitations will have a restrictive effect on many plans which have favored the highly compensated physician. As a result there should be an abundance of funds available, which in the past went to contributions to qualified plans, and now presumably will have no place to go. For information, call (609) 896-1766.

MALPRACTICE CRISIS?

Better medical care, inspired by multi-million dollar suits and new laws making it easier to sue, resulted in a sharp decline in medical malpractice claims in the past five years, states a report released by the Rand Corporation, a private, nonprofit institution.

Roberta Rilter, president of the California Trial Lawyers Association, said the Rand study simply confirmed what her organization has long contended—"the doctors caused the malpractice."

"The 'knee-jerk' reaction of the California Trial Lawyers Association president is extremely misleading," challenged Peter Sweetland, president of the New Jersey State Medical Underwriters, Inc., the administrative organization for the Medical Inter-Insurance Exchange of New Jersey. "It is true that the study does imply a major factor in the number of professional liability claims and suits is due to professional negligence, however, to limit any conclusions to that observation alone is totally misleading. The fact still exists that more medical professional liability actions are unsuccessful than in any other field that I know of.

"While I do not necessarily agree that there are significant errors in the data used in the study, there is a major weakness in the fact that the information cuts off in 1978. There is little argument that the number of claims and suits asserted dropped off in 1976 and 1977. The Institute failed to observe that most suits saw a resurgence by 1979 and 1980. Most companies would agree today that the gradual increase in frequency has resumed back at the pace which existed prior to 1975.

"If I have one overall conclusion about the study, I believe it is a fine start, but heavily underlines the need for a cooperative data gathering effort among doctor and hospital-owned companies to fill in the next episode."

DRGs

On June 30, 1983, *McLaughlin's Beat,* a one-half hour program on the New Jersey Public Broadcasting System, presented a discussion on the DRG program, with panelists Dr. Goldstein, Commissioner of Health, Dominick Comissi, New Jersey Hospital Association, and Vincent Maressa, MSNJ.

The Health Department maintains that the DRG program is cost effective. Commissioner Goldstein stated DRG hospitals have reduced the average length of stay by two days and Blue Cross is only requesting an inflationary rate adjustment.

Mr. Maressa maintained that the focus on the length of stay is meaningless if the base rate increases. The only valid measurement of effectiveness is a hospital-by-hospital comparison of DRG reimbursement *v* controlled charges.

TABLE
Comparison of Coverage and Benefits

Benefit	MSNJ Program	Direct-Payment
Coverage extended to unmarried children	End of calendar year child attains age 23	End of calendar year child attains age 19
120 days paid in full semiprivate care	All conditions	Limited to 20 days for mental conditions, TB, drug addiction, contagious diseases, and alcoholism
Out-of-state non-member hospitals	120 days fully paid semiprivate care	50 percent of reasonable charges to maximum of $100/day
Lifetime maximum benefit	Unlimited	$200 deductible to $250,000 $500 deductible to $100,000 (May be assigned because of health)
Outpatient mental care lifetime maximum benefit	Unlimited	$2,500 under both deductible plans

Mr. Comissi indicated NJHA has not formed an opinion, considers the program experimental, but does favor prospective rate making.

ASSOCIATES

The MSNJ Statewide Blue Cross/Blue Shield and Major Medical Programs provide exceptionally comprehensive coverage and benefits. In comparison to direct-payment coverage, these programs offer many advantages (Table).

The Blue Cross/Blue Shield Program had favorable claims experience for the year ended November 30, 1982. This allowed the additional premium required to fund the Program for the upcoming year to be kept to approximately 12.1 percent for the experience rated under-age-65 group for Blue Cross/Blue Shield. The rates for the age-65-and-over group also were increased between 15 and 21 percent depending upon the type of contract.

During its second year of operation, the Blue Shield 14/20 Series became even more popular among MSNJ members. In that time, enrollment had increased over 58 percent. This option provides the highest benefit payments of the fixed-fee benefit plans available through the Society.

The new computer terminal, connected directly to the Blue Cross/Blue Shield enrollment and claim files, provides direct access to the system and will allow the plan administrators to answer inquiries for participants immediately.

During the year, the Major Medical Program increased the annual maximum benefit from $250,000 to an unlimited benefit. This maximum benefit applies to each covered person per calendar year. It covers all applicable major medical benefits except for out-of-hospital treatment of mental conditions which are limited to a maximum annual payment of $1,000 per person. The increased annual maximum benefit, and the additional protection it provides, is necessary to keep your coverage in line with the increasing cost of medical care.

The claims experience for the major medical program has continued to improve. However, due to previous years' experience and inflation, it was necessary to increase the monthly premium rate an average of 21.5 percent.

Participation in the Group Dental Insurance Program has continued to increase as more MSNJ member doctors realize the value of this Program because this type of coverage usually is not available on an individual basis. Enrollment went up by 60 percent over last year bringing, the total participation to 960.

The Dental Program provides benefits for the following categories: preventive/diagnostic care; basic care; major care; and orthodontia.

The annual maximum benefit for the first three categories is $1,000 per person while the orthodontia category provides a $1,000 lifetime maximum benefit. There is a $50 calendar year deductible per person with a three-deductible limit per family.

Premium rates for the dental program were increased 30 percent effective April 1, 1983. However, it is not unusual to receive a significant premium rate increase in the first year of a dental insurance program. This is because the first one or two years always are subject to high claim utilization as participants receive needed dental services that were neglected in the absence of insurance.

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Liability Claims and Expert Witnesses

The 1982 core survey of the AMA's Socioeconomic Monitoring System, conducted in the second quarter of 1982, consisted of interviews with 3,817 physicians from a sample representative of the population of nonfederal care physicians, excluding residents.

The incidence of claims is measured by the average number of claims per 100 physicians, as indicated in the Table. The trend clearly is one of increasing vulnerability to claims for all physicians. This result holds true regardless of physician specialty, location, type of practice, or sex. For all physicians, the average incidence of claims in recent years has doubled, increasing from 2.9 per 100 physicians per year prior to 1976, to 6.2 claims per year for the past five years.

Experience with liability claims has not been distributed uniformly across specialties. Obstetrician/gynecologists, surgeons, and radiologists are more susceptible to claims than other specialists. Ob/gyns had the highest average incidence of claims (14.0 per 100 physicians per year) as well as the greatest percentage increase in annual claims since 1976. Psychiatrists and pediatricians incurred claims at the lowest annual rate both prior to and after 1976.

In addition to variation across specialties, current and past experience with liability claims differ by type of practice and location. While solo physicians experienced an increase in claims of 93 percent, those in partnerships and groups experienced increases of 121 and 123 percent, respectively. Although solo and group physicians incurred claims at approximately the same rate prior to 1976, group physicians have experienced 19 percent more claims than physicians in solo practice in the last five years.

Physicians in the northeast and north central regions of the country experienced a greater percentage increase in claims than those in other regions. In both regions, the incidence of claims increased by about 145 percent. At the other extreme, physicians in the west were least affected by the recent trend; the percentage increase for these physicians was only 52 percent.

Female physicians have been affected less seriously by the growth in claims since 1976 than their male counterparts. Prior to 1976, women incurred about 25 percent fewer claims than men. However, since 1976 female physicians have reported only 50 percent as many claims as male physicians. Pennsylvania Medical Society Liability Insurance Company, *Patient Newsletter,* Vol. 5, No. 3, May 1983.

NO WELCOME MAT OUT FOR IMPORTED EXPERTS

Travelling "hired guns" won't make the trip to Mississippi to testify in malpractice cases unless they are familiar with the medical territory, now that the state's highest court has clarified their status.

A lower court decision in favor of a plaintiff who won his case largely on the basis of expert testimony offered by an out-of-state witness, went up on appeal and a landmark unanimous ruling by the Supreme Court of Mississippi was rendered that only slightly expands the locality doctrine. (*King v Murphy,* Mississippi Supreme Court, No. 53, 429, November 1982.)

The initial malpractice case was filed by a logger whose leg was gashed by a chainsaw and who subsequently underwent above-the-knee amputation. He was treated by a general practitioner at a small hospital.

Richard Gardner, M.D., Fort Myers, Florida, testified as an expert witness for the plaintiff that nearly everything the rural doctor did in this case was improper and negligent.

During the trial it was brought out that Dr. Gardner, an orthopedic surgeon, was trained in metropolitan areas in Massachusetts and New York, had never practiced in Mississippi, and had no knowledge of standards of care in the rural area in which the case occurred.

The Supreme Court reversed, remanding the case for a jury trial on the merits, holding that "the standard of care by which the acts or omissions of physicians, surgeons, or specialists are to be judged shall be that degree of care, skill and diligence practiced by a reasonably careful, skillful, diligent, and prudent practitioner in such field of practice or specialty in this state, and for a reasonable distance adjacent to state boundaries."

The Court said that while not prohibiting expert testimony from nonresident physicians, such a witness should be "knowledgeable of, and familiar with, the statewide standard of care."

DID YOU KNOW . . .

Michigan Physicians Mutual Liability Company will make awards of $1,000, $500, and $250 to allopathic and osteopathic physicians-in-training in the state who write the

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Director of Special Projects.

best 2,500-word articles on some phase of risk management? It is the second year that the company has offered the Robert E. Rice Risk Management Awards.

A record high $119 million from a Houston court benefits Andrea Ferris, age two, who suffered brain damage because of alleged oxygen deprivation before and during cesarean section of mother Linda? *Medical Liability Monitor,* Vol. 8, No. 4, April 29, 1983.

Oregon's single largest verdict in a medical malpractice suit—$2.4 million—was returned against a hospital and a family practitioner late in 1982? *Medical Liability Monitor,* Vol. 8, No. 2, February 28, 1983.

Florida's insurance commissioner has submitted two-pronged legislation with controversial provisions: (1) every medical doctor would be required to provide proof he has a minimum of $450,000 in malpractice insurance in order to obtain or retain a medical license; (2) the level at which the financially troubled Patient Compensation Fund would pick up a doctor's liability for awards would rise from $100,000 to $150,000? *Medical Liability Monitor,* Vol. 8, No. 2, February 28, 1983.

PHYSICIAN TO PAY MORE FOR ATTORNEY'S FEE THAN FOR AWARD

A $20,000 award of attorney's fees to a patient who obtained a $15,000 malpractice award from a physician was not an abuse of discretion, a Florida appellate court ruled. The physician contended that the award of attorney's fees clearly was excessive. The appellate court rejected the argument that the dollar amount of recovery controlled the award of attorney's fees. Noting the complexity of the litigation, the hours expended in preparation and trial, and the skill and expertise of the patient's attorney, the court said the trial court did not abuse its discretion in awarding $20,000 in attorney's fees, *Baker v Varela,* 416 So. 2d 1190 (Florida District of Appeals, July 2, 1982). *The Citation,* Vol. 46, No. 7, January 15, 1983.

TABLE

Average Incidence of Physician Liability Claims by Specialty, Region, Type of Practice, and Sex

	Annual Claims per 100 Physicians	
	1976 to 1981	Prior to 1976
All Physicians	6.2	2.9
Specialty		
General/family practice	5.1	2.3
Internal medicine	5.2	2.1
Surgical specialty	9.2	4.5
Pediatrics	3.6	1.5
Obstetrics/gynecology	14.0	5.3
Radiology	5.9	3.1
Psychiatry	1.9	1.0
Anesthesiology	5.2	2.6
Other	3.7	2.1
Region		
Northeast	7.6	3.1
North Central	6.2	2.5
South	5.2	2.3
West	6.4	4.2
Type of Practice		
Solo	5.8	3.0
Partnership	7.5	3.4
Group	6.9	3.1
Other	4.9	1.9
Sex		
Male	6.5	3.0
Female	3.2	2.3

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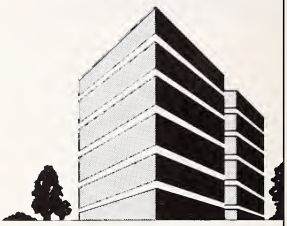
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Medical Discipline in New Jersey: A System in Need of Revision

The present system of medical discipline in New Jersey is tainted by a merger of functions within the attorney general's office and the State Board of Medical Examiners. This situation produces an insurmountable bias against a responding physician.

It is not unusual for a given deputy attorney general to advise the State Board at an executive committee meeting to file a formal complaint against a physician and, subsequent to that act, to become the prosecuting attorney. Meanwhile, the State Board transforms itself from the role of accuser to the role of adjudicator. Fundamental fairness dictates that there be no appearance of influence and most importantly that there be no actual influence exerted by the prosecutor over the Board. Both principles routinely are violated by this process in spite of the strongly declared position of our courts:

> Representatives of the public, acting in a judicial or quasi-judicial capacity must be required to perform their duties free of any interest . . . possessing the potentiality of influencing their judgment. Board of Education of WO *v* Inter. Union Eng. 109 N.J. Super 116, 120 (1970).

In two cases currently pending in the appellate division, a deputy attorney general prosecuted both cases while that deputy attorney general's supervising attorney acted as advisor to the Board in its closed session.* This is no different than the participation of a prosecutor in the deliberations of a jury when one of the prosecutor's assistants tried the case on behalf of the state. Obviously, neither situation should be permissible and both constitute a blatant failure of all notions of due process and fundamental fairness. In both cases, the issues involved were the credibility of witnesses. In each case, the administrative law judge determined that the state's witnesses were not believable. The administrative law judge consequently recommended that the complaints be dismissed. In each case, the deputy attorney general prevailed upon the Board to disregard the decision of the administrative law judge and to find the physician guilty. The State Board reversed the administrative law judge in each case and found the doctor guilty.

A review of the actions of the State Board of Medical Examiners in contested cases from 1976 to the present is enlightening. From 1976 until the Board began transferring matters to the Office of Administrative Law, 20 cases were heard to conclusion by the Board or its designee. In 16 cases, the Board or its designee found the doctor guilty. In the other four cases, the designee found the doctor innocent and the Board then reversed in each and found the doctor guilty. One of the reversed cases was heard by a former presiding judge of the appellate division who has considerable status as a jurist. While these results might arguably be attributable to the way cases were selected for prosecution, subsequent history dictates otherwise. Beginning in late 1979, the Board began transferring cases to the Office of Administrative Law for initial decision. Twenty-four cases have been heard by administrative law judges. Twelve cases resulted in a finding of guilty by the administrative law judge, while 12 cases resulted in a finding of innocent.

In 4 of the 12 guilty cases, the Board imposed penalties greater than those recommended by the administrative law judge. In 1 case, the Board materially reduced a penalty.

From 1979 on, the Board lost as many cases as it won. From 1979 until 1982, the Board did not reverse a decision of an administrative law judge. In January 1982, the appellate division, In re Jascalevich, 182 N.J. Super 455 (1982), ruled the Board had the right to reverse the decision of an administrative law judge in limited circumstances. Since that decision, there have been six cases heard by administrative law judges that resulted in a finding of innocent. Five of the findings of innocent have been reversed by the Board. These findings were all based on contested facts. The sixth case was not reversed by the Board. It, however, was based on a procedural ruling.

Forty-four cases have been adjudicated by the Board since 1976. Nine of the guilty verdicts occurred despite initial decisions to the contrary. Each innocent verdict on the merits, i.e. contested facts, occurred between initiation of referrals of the Office of Administrative Law and the Jascalevich decision. Since Jascalevich, each case decided on the facts has been decided against the doctor. Before the process of referral to the Office of Administrative Law in 1979, each case on the merits was decided against the physician.

If the Board of Medical Examiners can overrule an administrative law judge on issues of expertise and factual determinations, the Office of Administrative Law and the process of administrative hearing in New Jersey is nothing more than an exercise in futility. It is apparent that the Board has lost sight of its role as an independent and fair adjudicator. This situation cannot be permitted to continue. Litigation and legislation must be pursued to assure physicians of the same fundamental fairness and due process of criminal defendants or at least civil litigants.

Vincent A. Maressa

*MSNJ is appearing amicus curiae in both these cases.

Live or Die

On Saturday, April 23, 1983, "The New York Times" reported that the father of a five-month-old girl who died and whose liver was donated to a Tennessee baby was arrested in connection wih the baby's death. The father was charged with murder of his daughter.

The Deputy Warren County Coroner, Kevin Kirby, stated that the baby girl suffered from "shaken child syndrome," which occurs when a child is shaken violently from the upper arms and shoulders. The shaking can lead to rupture of brain vessels and heart-lung failure. In addition, the autopsy at Louisville's University Hospital showed that the girl had suffered recent bruises on the buttocks and had a skull fracture.

The heartache, past, present, and future, implied in the above-mentioned story is too great for words, but it deals with two issues: child abuse and high technology. What can we learn, as physicians, to help in the care of children, and in our counsel for parents?

First, the abuse of children is a recognized pastime, at least in Western cultures. The truly remarkable *History of Childhood* (edited by DeMause) makes clear that infanticide, neglect, and physical and sexual abuse were the custom through most of time since written records about childhood have been available.[1] Adults who care for a child may project onto that child their own unconscious feelings; they may use the child as a substitute for an adult figure of importance to them or they may attempt to provide appropriate nurture in the light of the child's reality needs. Regrettably, the first two general mechanisms have characterized adult caretaking of children for most generations of recorded history.

The legal obligations of physicians who see a neglected or abused child and the medical and social help available to abusive parents clearly have been structured in New Jersey. Many hospitals and social and mental health agencies now sponsor effective teams for intervention and for prevention of repeated episodes. The medical practitioner must report suspicious cases, and should try to help parents to avail themselves of child abuse services.

The second consideration is the implication of change in the availability of medical resources. It probably is true that there is a physician surplus or maldistribution of physicians or both; but it also is correct that there is not enough money in this country to pay for an ever-increasing availability of expensive high technology procedures for all those who might benefit from that opportunity. The implication is that a choice will have to be made. Who will choose? The physicians? The administrators? The judges? The clergy? The consumers and their advocates? Tribunals, as if in a science fiction world, may determine who lives and who dies.

A child died and her father was accused of murder. Another child, with a fatal liver disease, received the liver transplanted from the abused child. The drama and implications of this larger-than-life tale are both horrifying and heroic. Some would say the first child was doubly abused. Others would escalate the meaning of these circumstances to divine intervention. What do you think?

We are fortunate in that this issue has been explored recently, with care and thoughtfulness in the *Journal of the American Medical Association.*[2-4] Physicians who contemplate occupying decision-making positions in the world of tomorrow would do well to review these recent cogent discussions. Avrum L. Katcher, M.D.

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Diabetes '83

Our editor, Arthur Krosnick, M.D., has added another feather to his cap—as editor of a new publication from the American Diabetes Association, *Diabetes '83.* This quarterly newsletter is for people who live with diabetes.

As Dr. Krosnick wrote in his premier editorial, "The American Diabetes Association is publishing *Diabetes '83* to help people gain more knowledge about diabetes so they can help themselves gain control over it. *Diabetes '83* will emphasize the basics: what diabetes is, how insulin works, how to deal with diet, medication, exercise, self testing, and much more. Diabetes '83 will keep the reader abreast of news from research and the government."

Diabetes '83 is free and published by ADA, 2 Park Avenue, New York; NY 10016. The initial issue was a rousing success and a giant step forward for patient education. G.H.

Committee on Publication

An amendment to the Bylaws of the Medical Society of New Jersey, adopted by the 1983 House of Delegates, expanded the Committee on Publication from three to six members. The new members, who were appointed by President Alexander D. Kovacs, M.D., are A. Olusegun Fayemi, M.D., Robert M. MacMillan, M.D., and Leon G. Smith, M.D.

The six-member committee, headed by Paul J. Hirsch, M.D., oversees the operations of *The Journal,* the monthly medical publication of MSNJ. G.H.

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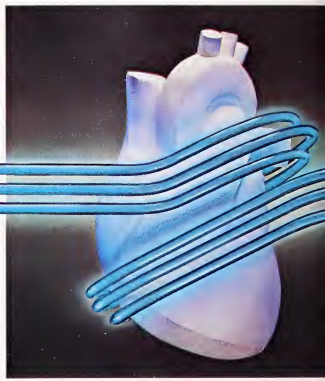
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ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES



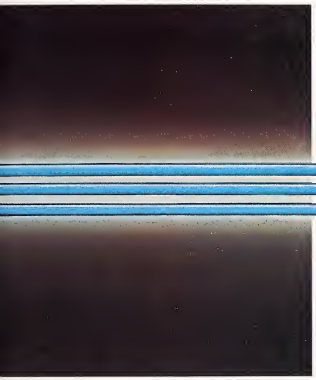
THE ONE TO COUNT ON FOR THE EXPERIENCE OF INDERAL—

A unique controlled-release formulation offers effective 24-hour beta blockade

Regardless of pH or contents in the GI tract, INDERAL is diffused from small spheroids at a controlled and predictable rate.

Providing clinical results equivalent to tablets

In controlled clinical studies, a single daily dose of INDERAL LA provided the same therapeutic response as equivalent doses of conventional INDERAL tablets. While there is little correlation between plasma levels and clinical effect in hypertension and angina, blood levels achieved with INDERAL LA are usually lower than those achieved with an equivalent mg dosage of conventional INDERAL due to differences in hepatic metabolism.



THE ONE™ TO COUNT ON

WITH ONCE-DAILY DOSAGE

In hypertension, angina, and migraine

Smooth 24-hour control

Unsurpassed simplicity and convenience

Single daily dosage for enhanced patient compliance

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

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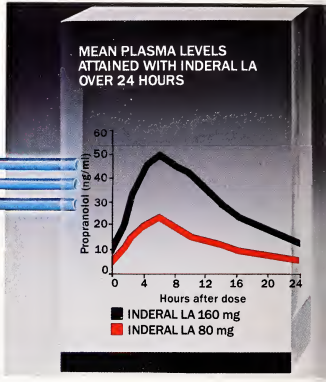
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INDERAL® LA

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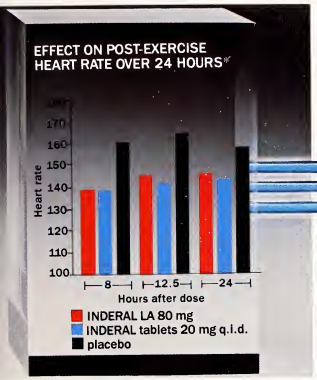
LONG ACTING CAPSULES



THE ONE TO COUNT ON FOR SMOOTH PLASMA LEVELS—

Sustained plasma levels

In pharmacokinetic studies, blood levels with once-daily INDERAL LA were found to be adequate to maintain sustained clinical effect throughout 24 hours. The unique controlled-release formulation of INDERAL LA minimizes differences between peak and trough plasma concentrations.



THE ONE TO COUNT ON

AND 24-HOUR BETA BLOCKADE

Provides therapeutic benefit throughout the day and night

In placebo-controlled trials, INDERAL LA was found to provide sustained 24-hour beta blockade as measured by decrease in heart rate, systolic blood pressure, and rate-pressure product. Patients taking once-daily INDERAL LA receive continuous protection from dose to dose–with therapeutic response equivalent to multiple daily doses of INDERAL tablets.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



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*INDERAL LA vs. tablets: N.S. at all hours measured.
*INDERAL LA vs. placebo: $p<.05$ at all hours measured.

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NEW

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES



THE ONE TO COUNT ON FOR INITIAL THERAPY IN HYPERTENSION

Start with 80 mg once daily

The usual initial dose is 80 mg INDERAL LA whether used alone or with a diuretic. Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control.

When converting patients from other beta blockers including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary.

Unsurpassed convenience and simplicity

Enhanced patient compliance



THE ONE TO COUNT ON

AND ANGINA

Simplified core therapy begins with 80 mg once daily

Although individual patients may respond to various doses, the average optimal dose in angina pectoris is 160 mg once daily.

Compatible with other conventional antianginal therapies

The experience and protection of INDERAL

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

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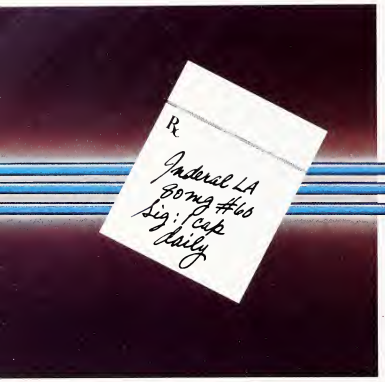
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THE ONE TO COUNT ON FOR THE EXPERIENCE OF INDERAL

NOW WITH ONCE-DAILY DOSAGE

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Smooth 24-hour control

Unsurpassed simplicity and convenience

Enhanced patient compliance

Three strengths for prescribing convenience

For arrhythmias, use conventional INDERAL® tablets

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ONCE-DAILY INDERAL® (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL LA brand of propranolol hydrochloride
(80 mg, 120 mg, 160 mg Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length and diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased exercise tolerance.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of this membrane action in the therapeutic effectiveness is unclear.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta-blockade can be accompanied by suppression of the renin-angiotensin system. If this is a significant mechanism of action of propranolol, the resultant reduction in angiotensin II may also contribute to the hypotensive effect.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially to control exertional dyspnea, angina-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the heart's oxygen demand which is jeopardized which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are adequately digitalized and receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) – PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical laboratory tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be carefully observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential in 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day. There was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C: INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands, thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation; mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION – *Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS – *Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosages exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE – *Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS – 80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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PHYSICIAN LEGAL BULLETIN

Misdiagnosis of Acute Myocardial Infarction*

JAMES E. GEORGE, M.D., J.D., JONAS BRACHFELD, M.D.,
MADELYN S. QUATTRONE, J.D.**

Allegations of misdiagnosis form a substantial portion of all malpractice suits. Physicians may take some limited comfort from the fact that a mistaken diagnosis may not be sufficient grounds for a successful medical malpractice suit. Before a physician can be held liable for misdiagnosis, it must be shown that the erroneous diagnosis was arrived at in a negligent manner and that the misdiagnosis caused damage to the patient. Often, the question of liability will depend on whether the physician elicited a full history, performed the usual and customary physical examination and appropriate diagnostic tests, and accurately interpreted the results. When it is determined that the physician acted in accordance with the accepted standards of the specialty, the physician cannot be held liable for an erroneous diagnosis.

This issue of the *Physician Legal Bulletin* presents several clinicolegal case studies involving misdiagnosis of impending myocardial infarction. The cases are presented with the belief that they may be helpful to practicing physicians and to those physicians who may be called upon to express an opinion as an expert witness in such cases.

A typical scenario is as follows. A middle-aged man, previously in good health, is seen in a physician's office by a physician covering for the patient's own physician, or by an emergency physician in the hospital emergency department (ED). A physician new to this patient obviously is handicapped by not knowing the patient's response to symptoms nor his judgment in seeking followup. The ED physician is handicapped doubly. Both the patient and the community may be strangers to him. The patient complains of indigestion or chest pain, but often there are atypical features that suggest clinical entities other than the true diagnosis. Digestive symptoms may predominate. Location of the pain may be atypical; for example, a patient with a chronic back or neck problem may report more severe pain than usual in his accustomed site of discomfort. A recent accident with trauma to the chest or elsewhere may draw attention away from the real problem. Often, however, the significance of the abrupt onset, the severity, or the scope of the clinical picture with its associated systemic manifestations (sweating, malaise, and weakness) has not been appreciated. An electrocardiogram (ECG) may or may not be obtained. It may be interpreted correctly as normal or as abnormal but nonspecific. Occasionally, the clearly diagnostic ECG features are subtle and missed entirely but reported "officially" the next day. Almost always, there is no arrangement for followup and no provision for the patient to call someone if he is not doing well. (The patient finds this particularly confusing in the case of a "covering" physician.) His condition deteriorates steadily at home and he is brought to the hospital in extremis or dead, or he may die suddenly at home.

THE ULMA CASE

The case of *Ulma v Yonkers General Hospital et al.*, 384 N.Y.S. 2d 201 (1976) illustrates these clinicolegal issues with striking familiarity. The facts reveal that Mr. Ulma was brought to the emergency department (ED) complaining of abdominal pain and hyperventilation. The intern on duty examined the patient and ordered a blood test and urinalysis. The intern telephoned the results of the tests and the patient's complaints to the physician who was "on call" for the patient's family physician.

On the basis of this information, the on-call physician diagnosed the patient's condition as gastroenteritis. He prescribed medication for the pain and nausea and instructed the intern to send the patient home.

One hour later the patient, accompanied by his worried family, returned to the ED seeking admission. The intern telephoned the on-call physician who responded by promptly meeting with the patient in the ED. He conducted a physical

*This article was prepared in conjunction with Jonas Brachfeld, M.D., Director, Heart Station, Zurbrugg Memorial Hospital, Rancocas Valley Division, Willingboro, and Associate Clinical Professor of Medicine, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania.

**From the Department of Professional Liability Control, MSNJ. Correspondence may be addressed to Mr. Ron Rouse, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.

examination which did not include an ECG. The examining physician reaffirmed his diagnosis of gastroenteritis and released the patient.

Mr. Ulma, his wife, and daughter left the ED and walked through the hospital parking lot to their car. Before reaching their automobile, Mr. Ulma collapsed and died. Postmortem examination revealed that he suffered from occlusive coronary arteriosclerosis. The patient's wife subsequently sued the on-call physician alleging that he negligently failed to take an ECG and negligently misdiagnosed her husband's illness.

"In cases of alleged misdiagnosis, the legal question is: What should the physician have known and when should he have known it?"

At trial, the patient's expert medical witness testified that the immediate cause of Mr. Ulma's death was ventricular fibrillation. The question of liability in the Ulma case turned on two points: (1) whether the physician was negligent in failing to order an ECG, and (2) whether the misdiagnosis, which may have been traceable to the ECG failure, caused Mr. Ulma's death. The trial court applied the standard of medical care which was acceptable in 1970 when the events occurred. The judge instructed the jury that even if they were to find that the physician was negligent in failing to order an ECG, the physician could not be held liable unless the jury could determine that the failure to order the ECG caused the patient's death.

The jury determined that the patient's instantaneous death in the parking lot was "beyond the control of medicine." This verdict was upheld on appeal.

If the facts in the Ulma case were to arise today, it is most unlikely that any jury would reach the same result. Patient expectations as well as standards of care have risen dramatically in the past decade as have the diagnosis and treatment of myocardial infarction. Today, there is a great concern to prevent or minimize infarct extension if at all possible. Some even advocate immediate angiography and enzyme injection to dissolve thrombosis in selected cases. These procedures are not unfamiliar to the members of today's juries.

As the Ulma case illustrates, the plaintiff must prove a causal connection between the defendant physician's conduct and the patient's injury. The issue of legal causation was explored thoroughly in a noteworthy Pennsylvania case, involving a patient who died of a myocardial infarction while an ECG was being taken.

THE HAMIL CASE

The legal history of the case of *Hamil v Bashline* 392A. 2d 1280 (1978) is long and tortuous. As of this writing, the case is scheduled for its fourth trial by jury.

The facts of this case reveal that a few minutes before midnight on May 31, 1968, Mrs. Hamil telephoned the Bashline Hospital and informed the night supervisor that her husband was experiencing severe chest pain. The night supervisor instructed her to bring Mr. Hamil to the hospital. When Mr. and Mrs. Hamil arrived at the ED, the emergency physician was nowhere to be found. Another physician, Dr. Johnston, was located. When advised of Mr. Hamil's condition, Dr. Johnston took Mr. Hamil's pulse, but did not speak to him or his wife. Dr. Johnston ordered an ECG. However, the machine failed to operate apparently because of an electrical problem. The physician ordered another machine and then left the hospital. No other machine could be located and the patient received no treatment while in the ED.

Mrs. Hamil then left the ED and drove her husband to the office of a private physician. Mr. Hamil subsequently died of a myocardial infarction while an ECG was being taken in the private physician's office.

Mrs. Hamil later brought suit against Bashline Hospital. She charged that the hospital failed to use recognized and available methods of treating her husband's myocardial infarction.

At trial, the plaintiff's expert medical witness outlined the customary treatment procedures that are undertaken to diagnose and treat chest pain until it can be determined that the patient is not suffering a heart attack. The plaintiff's expert witness then gave his professional opinion that had the hospital used the methods he described, Mr. Hamil would have had a 75 percent chance of surviving the heart attack. The plaintiff's physician expert witness also testified that this substantial chance of recovery was terminated by the defendant physician's failure to provide prompt treatment.

The trial judge ordered the expert's testimony stricken from the record. The judge ruled that the witness's testimony failed to meet the proper standard for medical experts. The standard in Pennsylvania requires an expert medical opinion to be based on a reasonable medical certainty that the death was caused by the defendant's failure to use reasonable care. The trial court then directed a verdict in favor of the defendant hospital.

On appeal, the appellate court reversed the trial court and granted a new trial. The jury in the second trial found that the hospital acted in a negligent manner. However, it found that the plaintiff had failed to prove that the hospital's negligence was the proximate cause of Mr. Hamil's death. The plaintiff appealed on the grounds that the trial court had erred in instructing the jury. The appellate court, over strong dissent by some of its members, affirmed the judgment in favor of the hospital. The plaintiff then appealed to the state's highest court.

The Pennsylvania Supreme Court recognized the difficulty faced by the plaintiff in isolating the causal factor in cases like Mr. Hamil's. The court ruled that well-established principles of tort law, applicable to this type of case, permit the issue of causation to go to the jury upon less proof than usually is required. The Court held that once a plaintiff has demonstrated that the defendant's negligent performance or omission increased the risk of harm to the plaintiff, sufficient evidence exists to allow the jury to find that the increased risk was a substantial factor in bringing about the injury.

The Pennsylvania Supreme Court ruling in the Hamil case, as well as similar decisions by high courts in other jurisdictions, has significantly lessened the legal barrier which plaintiffs must overcome to prove legal causation in cases alleging misdiagnosis. The following California case illustrates this point.

A lawsuit filed in Alameda County Superior Court, No. 524844-9 (1979) alleged failure to diagnose an impending myocardial infarction. The parties settled out of court for $500,000. The facts reveal that the patient was a 32-year-old attorney who visited the defendant internist complaining of substernal chest pain, radiating to the left arm. The patient

complained of two such episodes over the previous several days. He reportedly told the internist that on one occasion the pain was precipitated by eating chocolate. Physical examination and an ECG proved normal. The internist concluded that the patient's distress was caused by esophagitis. He prescribed an antacid. A stress ECG was not obtained.

The episodes of pain persisted for the next three days. The patient eventually visited the emergency department of Alta Bates Hospital in Berkeley where he was seen by the defendant internist and by an emergency physician.

An ECG, chest x-ray, and enzyme studies proved unremarkable. On physical examination the emergency physician detected an S-3 gallop. The defendant internist disagreed with the emergency physician's determination. He reaffirmed his original diagnosis of esophagitis and prescribed valium and cimetidine. He instructed the patient to visit him in the office the next morning.

The next morning the patient complained of persistent substernal pain with radiation into the left arm. Another ECG proved unremarkable. The internist agreed to hospitalize the patient the following morning if the pain did not subside. That night the patient collapsed and died at his home.

Postmortem findings revealed a fresh thrombosis of the left anterior descending coronary artery, near its origin. Moderately severe atherosclerosis of all three major coronary vessels also was noted.

Had the case proceeded to trial, the plaintiff's attorney readily could have argued that the emergency physician's detection of what he believed to be an S-3 gallop should have alerted the internist that he was dealing with something more serious than a case of esophagitis. By persisting in his diagosis in the face of the patient's continuing chest pain, the internist's mistaken diagnosis evolved into a negligent misdiagnosis.

COMMENTARY

Dependency on laboratory studies contribute to the abandonment of common sense and may lead to a catastrophic outcome. It may seem trite to emphasize that common sense and good judgment should take precedence over laboratory studies, but this axiom appears to have been overlooked in many cases. The role of the ECG is particularly ambiguous in this setting. It is true that the plaintiff will raise a hue and cry when an ECG was not obtained and a cardiac catastrophe developed subsequently. However, it equally is difficult to explain, even in the face of a normal ECG, why the patient was not then treated as an acute myocardial infarction suspect.

Once a decision is made to handle that patient as a suspected acute myocardial infarction there is no time to be lost, since life-threatening arrhythmias occur most often in the first hours after onset of symptoms. Allowing the patient to sit in the ED without adequate monitoring while laboratory work is being obtained, administrative details are being cleared up, or the attending physician is being called, may result in golden minutes lost that eventually may prove vital. Cardiac defibrillation can be carried out successfully without any additional measures only in a patient who has had ventricular fibrillation for less than a minute or so, and therefore only in a setting of adequate electronic monitoring. In the absence of such monitoring, prompt intervention within such a brief interval usually is not possible and full-scale resuscitation then usually is required. Such resuscitation may result in a totally unimpaired patient perhaps less than one-tenth as often as successful, simple defibrillation. Cardiopulmonary resuscitation after unwitnessed collapse, or after ventricular fibrillation supervening at home, rarely results in an adequately functioning person.

EXPERT WITNESS TESTIMONY

To hold a physician liable for a misdiagnosis, the plaintiff must prove that the misdiagnosis was negligently arrived at and resulted in injury to the patient. Expert testimony will be required for both the plaintiff and the defendant.

There are four basic issues which the cardiologist who is an expert witness must help resolve:

1. Was the management appropriate to the situation?
2. Did an error in management contribute materially and substantially to the outcome?
3. Who were the persons or agencies responsible for the alleged error?
4. What would have been the victim's life expectancy and work capacity if the outcome had been satisfactory?

"The standard of care for suspected cardiac patients is to treat the patient as a potential cardiac emergency until proved otherwise."

The physician who is new to the role of expert witness must learn to sift through voluminous files in order to focus on these crucial issues. If he reviews material submitted to him in an objective, scientific fashion, he will be able to reach dispassionate conclusions and will not feel defensive when they are challenged.

It is helpful to acknowledge, during the preparation of the case, some of the weaknesses of the position the attorney proposed to establish. Above all, the physician must come to court with respect for a process, albeit alien to his own training and experience, which is designed to arrive at the truth, and he must accept the adversary system as part of this process. He thus may overcome the discomfort experienced at entering an unfamiliar arena, achieve superior credibility, and maintain professional self-esteem.

Not infrequently, there will be controversy as to the facts. The expert should base his opinion assuming accuracy of the account presented by "his side." However, he must expect that during cross-examination his fairness will be tested by the presentation of a different set of assumptions by the opposing side.

The process of screening or triage must be carefully differentiated from that of diagnosis. Textbooks and journals describe in detail how the diagnosis should be arrived at and how the "acute myocardial infarction suspect" should be handled. What is described less clearly is what are reasonable grounds for even suspecting the possibility of a myocardial infarction and what are suitable grounds for dismissing it. Multiple clues, often not clearly medical ones, may be utilized for such judgment. Previous medical history, family history, and assessment of risk factors obviously are important elements. However, the setting of the encounter often is a valuable clue. A patient presenting to the ED having stopped work is far more suspect than one seeing his family physician during evening office hours. A phone call from

someone, even a stranger, describing the sudden onset of chest pain has different significance than a call for an appointment by a patient who is known to have a variety of complaints and who now has chest pain "in the evening, after a hard day, when he feels tired."

Admittedly, controversy may prevail regarding the appropriateness of certain judgments. However, in many situations, there is a definite answer to the question: Assuming certain facts, was the suspicion of an acute myocardial infarction inevitable or was the alleged error of overlooking this possibility beyond the limits of the state of the art? It is here that the practicing cardiologist is truly at an advantage since he is on "the firing line" daily. Therefore, he may refuse to recognize generalizations published in textbooks as "authority" used to cross-examine him.

It is not sufficient to state that management was not consistent with medical standards without explaining how this has affected the outcome. This involves delicate medical judgment. The precise cause of death often is equivocal, even in acute myocardial infarction and some medical judgment must be brought to bear on what is the most probable cause of death. Sudden death may have been the result of extension of infarction, myocardial rupture, or extensive injury leading to pump failure, and therefore may not have been preventable even if the patient had been in the hospital. Other diagnoses such as a dissecting aneurysm, must be considered. The legal concept of causation is complex but will be handled by the attorney. The medical expert will be needed to provide the necessary material for the legal arguments.

Finally, assuming a patient would have survived the acute episode, expert judgment then is required to give an estimate as to his long-term survival potential and estimated work span. Even in the absence of controversy, such estimates are difficult to arrive at. Modern literature bases survival potential primarily on coronary angiography findings, but long-term survival with modern therapy, based on current clinical data, is not widely available. Many assumptions need to be made and specific details must be considered in order to project life expectancy and work capacity for a patient who might have survived had he been treated adequately. All these imponderables call for extensive judgment and experience, as often is the case in clinical matters.

CONCLUSION

Cases of unrecognized cardiac emergencies may be difficult to defend. By and large, these cases define an area of medicolegal exposure where conventional wisdom does not seem to apply. These claims were not frivolous, they were not brought about by a physician pursuing his bill collection efforts injudiciously, nor was the litigation the result of an unwarranted statement by another physician. They were not caused by antagonizing a patient or his family, although a few widows reported with great resentment the comment "please step outside and let us finish our work." They thought that if their version of the history had been heard, this might have altered the conclusions reached by the physician. Rarely is obvious negligence a factor.

In some cases "defensive medicine" may not protect the physician. In court, normal laboratory data by themselves may not be an adequate defense in cases of blatant errors in clinical management.

In many cases physicians can avoid charges of negligent misdiagnosis and mistreatment of myocardial infarctions by following this general rule: Assume the patient is a cardiac emergency until proved otherwise and admit the patient for observation. Although one cannot admit all patients with "chest pain," few would quarrel with the decision to admit for observation those patients with a suspicious history.

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

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eferences: 1. Wilms RL, Karacan I: troduction, chap. 1, *Sleep Disorders: iagnosis and Treatent*, edited by Wilms RL, Karacan I, azier SH. New York, hn Wiley & Sons, 978, p. 2. **2.** Data on e, Hoffmann-La oche Inc., Nutley, NJ. Kales A *et al: JAMA 41*:1692-1695, Apr 20, 979. **4.** Kales A *et al: Clin Pharmacol 17*:207-3, Apr 1977 and data file, Hoffmann-La oche Inc., Nutley, NJ. Kales A: Data on file, offmann-La Roche c., Nutley, NJ. Kales A *et al: Clin Pharacol Ther 19*:576-583, ay 1976. **7.** Kales A, charf MB, Kales JD: *cience 201*:1039-1041, ep 15, 1978. **8.** Frost D Jr, DeLucchi MR: *Am Geriatr Soc* 27:541-46, Dec 1979. Dement WC *et al: ehav Med 5*(10):25-31, ct 1978. **0.** Vogel GW: Data on le, Hoffmann-La oche Inc., Nutley, NJ. **1.** Karacan I, Williams dL, Smith JR: The sleep aboratory in the inves-gation of sleep and leep disturbances. Sci-ntific exhibit at the 24th annual meeting of the American Psychi-tric Association, Washington, DC, May 3-, 1971. **12.** Pollak CP, cGregor PA, Weitz-nan ED: The effects of lurazepam on daytime leep after acute sleep-vake cycle reversal. resented at the 15th nnual meeting of the ssociation for Psycho-hysiological Study of leep, Edinburgh, Scot-and, June 30-July 4, 1975. **13.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **14.** Kales A, Kales JD: *Pharmacol Physicians 4*(9):1-6, Sep 1970. **15.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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Guidelines for Optimal Handling of Chemically Impaired Physicians in a Hospital Setting

The Board of Trustees of the Medical Society of New Jersey approved the following recommendation: That the Board of Trustees endorse the "Guidelines for Optimal Handling of Chemically Impaired Physicians in a Hospital Setting." The Guidelines were written by Edward T. Carden, M.D., a member of the Committee on Impaired Physicians, and endorsed by the Impaired Physicians Program of the Medical Society of New Jersey. The following is the complete text of the "Guidelines."

BACKGROUND

Few hospitals have staff sufficiently expert and assertive about diagnosing and treating chemically impaired people. The health industry is far behind many comparably sophisticated industries regarding its employee assistance programs for personnel with chemical impairment. Little surprise then that the casualty surveillance for and disposition of chemically impaired physicians doesn't exist or relies on inadequately experienced personnel who may make decisions that hurt the institution and the sick physician.

To handle this problem correctly, we must realize that the welfare of chemically impaired physicians and of the public are inseparable; correct diagnosis and correct treatment of the established chemical addiction serves both groups simultaneously.

The experience of the Committee on Impaired Physicians of the Medical Society of New Jersey clearly has demonstrated that the only treatment modalities with any consistent effectiveness are oriented around the peer group processes, specifically Alcoholics Anonymous and Narcotics Anonymous. It, therefore, would be much more fruitful to be aggressive and assertive about implementing these treatment modalities earlier than groping for alternatives which experience clearly has shown to be temporarily effective, if at all.

Hospital trustees are being held more accountable for the quality of care rendered by their medical staff. They carefully should note the history of handling chemical impairment in airline pilots, the only professionals to rival physicians in potential harm to life and limb. Only when the Airline Pilots Association and the FAA combined forces in 1972 and devoted significant resources to correctly identify and treat addiction and to continue professional status after successful treatment, was any progress made in the airline industry.

IDENTIFICATION

Legalistic attitudes towards the clinical evidence of an addiction have produced a "conspiracy of silence." When they are perplexed about the motivational aspects of its cause and its cure, people understandably are unwilling to deal with a problem. Semmelweis and Lister had great difficulty motivating physicians to wash their hands because Koch and Pasteur had not yet produced the germ theory that explained why washing was necessary. So too, experienced addictionologists currently cannot refute all the counterproductive, preconceived notions about people who become addicts and consequently are frustrated by the late stages of the disease that present for treatment because of inappropriate handling by the people who were dealing with the disease victim during the earlier stages.

Institutions can improve this situation by a significant educational effort to bring their personnel to the beginning of wisdom (recognition of ignorance) about addiction and by establishing and publicizing an advocacy approach to the victims of this disease.

VERIFICATION

An expert addictionologist begins the intervention by establishing the diagnosis of a particular type of addiction(s) as definite, probable, possible, or unlikely. This is done by assessing evidence in a clinical, not a legalistic fashion; rumors and hearsay evidence are appropriate sources to be verified, especially when widespread.

Inexperienced people can be discouraged easily during this process by an unrealistic fear of lawsuits. The chemically impaired physician is invariably terrified of any unusual scrutiny or undue attention. He may threaten to sue, but this is more a manipulative effort that confirms the diagnosis than it is a realistic threat. A violently defensive response

*The material for this column is coedited by Arthur Krosnick, M.D., Editor of *The Journal*, MSNJ; Vincent A. Maressa, Executive Director, MSNJ; and James E. George, M.D., J.D., Director of the Department of Professional Liability, MSNJ.

during an intervention process can verify the presence of the addiction (even if there is no immediately positive response to the intervention).

INTERVENTION

An intervention consists of confronting an addict in a meaningful way about the reality of the addiction. This means breaking through the denial that inevitably is present and eliminating the addict's alternatives to appropriate treatment. Successful interventions require experienced intervenors who can facilitate a confrontation that is clear, honest, direct, loving (or at least caring), and safe, because unless a healing spirit permeates the confrontation, the victim will not and cannot expose any wounds. The intervenors must be experienced so they can decide on appropriate treatment. They also must decide on appropriate countermeasures if treatment is refused or unsuccessful. Delicate judgment is essential in all this, because the addict can bolt quite easily. At a later stage of the disease, success becomes more difficult.

CONFRONTATION

Often considered by the uninitiated as an act of superhuman boldness, confronting an addict is not particularly difficult when you understand denial as part of the disease. The intervenors should be motivated by concern for the victim and avoid any recriminations.

Confrontation is best done in the presence of people the addicted person perceives as caring for him. These people must be coached to put aside their frustrations and other negative feelings which the addict interprets as rejection. Rejection is familiar to the addict, and he handles it by becoming emotionally isolated, without penetrating denial.

Having a recovered physician addict help with the confrontation inspires hope that recovery is possible and confidence that the claims of advocacy are genuine. The family of the addict takes comfort from this recovered person; often they dramatically reverse any reticence to implicate an addiction and cooperate in pressuring the victim into treatment.

Intervenors must maintain control of each confrontation by skillfully avoiding the inevitable and often clever attempts by the addict to manipulate the situation, sometimes by disruptive behavior. When the addict learns that he cannot divert the attention of this process from his addiction, he may precipitously submit to the process and become grateful for being forced into appropriate treatment.

Sometimes there is compliance without submission. These unfortunate people require the most experience to detect and to deal with properly. They will inevitably relapse if they do not abandon the reservations they have about their sickness and how to get well.

TREATMENT

Allowing chemically impaired persons to select or control their own treatment is irrational. The impairment, by its very nature, usually precludes adequate insight and motivation to choose a successful treatment plan. Rather, the addict is predisposed to select therapy with one or more (usually all) of the following deficiences:

1. Treatment which does not prohibit the use of all sedative-hypnotic and narcotic drugs except under very tightly controlled inpatient circumstances such as surgery and detoxification.

2. Treatment based completely on an assumption that the addiction is secondary, rather than a primary behavior disorder.

3. Treatment restricted to outpatient status when the addiction clearly is in stages which require a controlled environment for successful initial therapy.

4. Treatment which overutilizes individual psychotherapy.

5. Treatment that does not recognize the absolutely essential role of various peer-group processes such as Alcoholics Anonymous and Narcotics Anonymous.

Besides avoiding the above deficiencies, therapy always should come from an institution or section of an institution that specializes in treatment of addictive disorders. Use outpatient treatment only if the physician can immediately achieve and maintain total abstinence from all mood changing drugs. Also, involve the family in the treatment.

"Hospital trustees are being held accountable for the quality of care rendered by their medical staff."

MONITORING

Chemical monitoring supplies objective evidence of what really is happening. The treatment institution should monitor the addicted physician to determine the need for additional treatment. It usually is unwise to merge treatment monitoring with a hospital's legitimate need to police its identified addicts.

When an addict behaves suspiciously, he should be given chemical screening immediately. (Currently, urine is the optimal biological fluid to screen.) If he refuses the screening, consider this tantamount to an admission of relapse, and deal with it appropriately.

Completely random urine samplings provide objective evidence that a person is recovering. Experience with addicts mandates, however, that all specimens be obtained under the direct vision of the chief of service or a designee because addicts can be very adept at switching samples. This can be embarrassing, but it must be done for the sample to be useful as irrefutable evidence.

Chemical monitoring must be highly individualized. Though the details are too complex to discuss here, some broad guidelines are possible. Any addict who has prompted official activity by a hospital should be considered a candidate for totally random (i.e. absolutely no warning) samples within the first two years of recovery. Make this known ahead of time so it won't be interpreted as mistrust. If the chief takes the time to get the sample personally, and uses an alias on the sample, it can save the addict unnecessary humiliation.

With increasing litigation in our country, both the institution and the physician may find this data invaluable to refute unwarranted allegations about clinical performance. An immediate precautionary sample is advisable whenever a recovering physician foresees the possibility of litigation from a clinical situation.

COUNTERMEASURES

"Enabling" is the term used to describe the behavior by the "significant others" that allows the addict's disease to progress, instead of being treated and arrested. There usually are two sets of enablers, one in the home and the other on the

ob. The consistent pattern is failure to execute appropriate ountermeasures as promised and/or agreed upon with the ddict.

Countermeasures must be forewarned thoroughly and ommensurate with the degree of dysfunction produced by he addiction. Countermeasures must be enacted, otherwise he individual involved becomes ineffectual against the dis-ase process. "Just one more chance" has incredible appeal o human beings, but making the addicted person respon-ible for all behavior is the only pattern that will save his or ier life. People often do not want to pay the price of a :ountermeasure (loss of a valuable employee, friend, or emporary and permanent disruption of a relationship), and so the addict pays for it with progression of the disease process.

HOSPITAL PRIVILEGES

Loss or curtailment of hospital privileges should be used to protect patients and to avoid enabling the addicted physician. This isn't easy. Hospital administrators would like to use disciplinary measures which revolve around their interaction with the addicted physician (first a warning and then a short suspension). Unfortunately, the involvement may be with very different stages and types of addiction for different physicians, making cookbook approaches to such countermeasures clinically invalid.

If a hospital is interacting with a physician's addiction for the first time, or adequate treatment (with none of the aforementioned deficiencies) is being mandated for the first time, officially restricting or curtailing privileges may be seen as punitive rather than therapeutic. A realistic evaluation of job capabilities always is an integral part of treatment and thus "self-imposed" restrictions may well evolve to avoid stress. These are best arranged between the chief of service, addictionologist, and patient. Discussion of these issues outside that small group is humiliating and should be avoided, provided the patient cooperates with the treatment program.

The chief of service and hospital administrator should agree upon loss of privileges for posttreatment recidivism, and the patient must be thoroughly warned. As much as possible, the agreement should reflect the degree of dysfunction produced by any recidivism, yet demand "permanent" total abstinence (for at least seven years*). Once an agreement is made and understood by all parties, forgiveness of anything but a solitary brief relapse which has mitigating circumstances is usually tantamount to "enabling."

No matter how advanced the disease, the prognosis for continued successful abstinence is excellent after two years of uninterrupted sobriety. An early guarantee that full reinstatement (with appropriate supervision) will occur once that contingency has been satisfactorily demonstrated is very therapeutic. Shorter time frames can be used for earlier stage disease with excellent results.

CONFIDENTIALITY

Even though a physician's addiction may be flagrant and widely suspected, all dealings must be done with utmost confidentiality, using the "need to know" rule for divulging information (e.g. to O.R. supervisors if the addict is a surgeon). Nothing can destroy a physician's confidence in his relationship with a hospital faster than discovering that something he considered personal and private has drifted into the local gossip circles.

With time, a recovering physician may become quite open about both the illness and his recovery; until then, no one else has the right to divulge this information. Also, any breach in confidentiality may inhibit future referral of impaired physicians to the established advocacy process.

FAILURES

A single hospital, even with an expert in charge of strategy, may not have sufficient leverage (using privileges only) to successfully intervene with every addicted physician on its staff. Weaving a single strategy from multiple institutions usually is difficult to arrange but it can be an extremely effective measure.

Many states have laws that require notifying licensing boards about the circumstances of all departures from any medical staff except under certain straightforward conditions. These laws enhance an institution's leverage for getting the diseased victim into treatment and should be used to do so.

Reporting physicians to licensing boards is not always effective. Occasionally, it may precipitate a suicide or other disaster and some physicians do not need to practice in order to continue their addiction. They also may move before the complaint can be processed. Legal compliance, lack of alternatives, and the track record of the particular licensing board in dealing effectively with addicts are the guidelines to use in reporting these physicians. The clinical issue is whether jeopardizing a career can save a life, and whether the degree of impairment is a public health hazard (don't forget that several Nobel laureates were chemically impaired for significant portions of their careers).

Experienced impaired physician committees of state or county medical societies will be of significant help in finding an optimal solution to any problem. Unfortunately, they are not available everywhere and are almost always staffed exclusively by volunteers.

*This time reference is used because at seven years, you are likely to be dealing with a very changed person whose problem should be considered almost "de novo" from the clinical standpoint.

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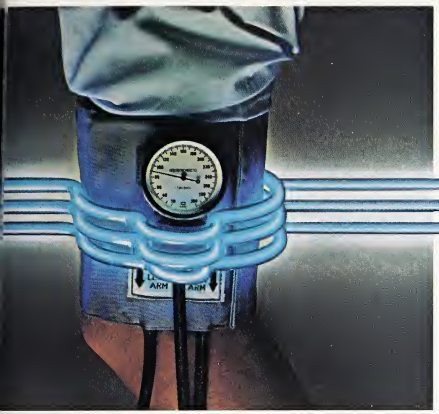
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INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curves (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower absorption of propranolol. Over a twelve (12) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered, especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of inappropriate renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and transient. Propranolol HCl has also been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and the duration of ejection. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is primarily harmful to the patient. There are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should not be prevented. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be considered in patients subject to bronchospasm

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache

The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, dyspnea, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be transient

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes), acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. General. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a further increase of intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential in 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to propranolol.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required discontinuation of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with achiness and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasis-form rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

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Campylobacter Gastroenteritis Associated with Raw Clams

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An outbreak of *Campylobacter jejuni* gastroenteritis occurred among participants of a firemen's banquet. Duration of illness ranged from two to seven days. Raw clams were associated with illness.

Marine mollusks, such as hard clams, filter large volumes of seawater during feeding activities, resulting in the concentration of bacteria such as coliforms or *Salmonella* within their bodies.[1] The association between ingestion of raw shellfish and enteric diseases such as typhoid has been recognized since the early 17th century. In the United States, current shellfish sanitation programs virtually have eliminated this source of typhoid fever. However, shellfish-associated outbreaks of gastroenteritis continue to occur.[2]

Numerous investigators have shown that the current shellfish standards based on coliform and fecal coliform counts do not correlate well with the presence of other pathogenic enteric bacteria or viruses.[1,3] We describe an outbreak of raw clam-associated gastroenteritis with strong evidence for *Campylobacter jejuni* as the etiologic agent.

CASES AND METHODS

In December, 1980, we were notified of an outbreak of gastrointestinal illness among a group of volunteer firemen and their families who had attended a catered banquet in Boonton. Interviews for symptoms of illness and food histories were obtained from 28 of the 31 persons (90 percent) who attended the banquet. A case was defined by the presence of either vomiting or diarrhea, or both abdominal cramps and fever after eating at the banquet.

Rectal swabs from seven ill persons were obtained four days after the banquet and transported the same day in Cary-Blair medium to the New Jersey State Department of Health laboratories. Specimens were tested for *Salmonella, Shigella, Campylobacter,* and *Vibrio* species. Additional stool specimens from 10 cases were tested for *Salmonella, Shigella, Campylobacter, Pleisomonas,* and *Aeromonas.* Confirmation of isolates and serotyping of *Campylobacter jejuni* was done at the Centers for Disease Control (CDC), Georgia.

Paired serum samples collected two weeks apart from five ill individuals were tested at CDC for Norwalk virus antibody using radioimmunoassay.[4]

RESULTS

Twenty-eight of 31 banquet participants (90 percent) were reached for a personal interview. Ages of attendees ranged from 16 to 68 years, median age was 51 years. Sixteen of 28 participants (57 percent) became ill 20 to 52 hours (median 36 hours) after eating. Symptoms included nausea (88 percent), headaches (75 percent), vomiting (69 percent), diarrhea (69 percent), stomach cramps (44 percent), and fever (38 percent). Duration of illness ranged from two to seven days, with a median of three days. There were no hospitalizations or deaths. Age-specific attack rates showed no consistent trend (Table 1). Families of 22 individuals (13 ill, 9 well) were recontacted in the following weeks. There were no reports of secondary cases. There also was no development of clinical hepatitis in this group.

Raw clams were the only food significantly associated ($P = 0.000006$) with illness (Table 2). Ill persons ate between 3 and 36 clams each (median 12). Only one person who ate raw clams remained well; this person ate 3 clams.

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TABLE 1

Age-Specific Attack Rates for 28 Banquet Participants

Age (years)	Ill	Total	Percent
11 to 19	2	2	100
20 to 29	3	5	60
30 to 39	0	3	0
40 to 49	3	3	100
50 to 59	5	6	83
60 to 69	3	9	33

Eleven of the ill persons submitted stool specimens for testing. Two rectal swabs and one stool specimen were positive for *Campylobacter jejuni*. One of these also was positive for *Salmonella enteritidis* serotype *derby*. Two of the *C. jejuni* isolates were serotype 33, while the third was a different serotype. No other pathogens were isolated. None of the five paired serum samples showed evidence for infection with Norwalk virus.

Illness in the three persons who had *Campylobacter* isolated from their stools was similar to that of the rest of the group. Their reported incubation periods ranged from 21 to 34 hours, and duration of illness ranged from 2 to 7 days. Nausea, vomiting, diarrhea, headaches, and fever were each reported by two of the three persons.

Although the rest of the banquet had been catered, the firemen had purchased one bushel of hard shell clams *(Mercenaria)* from a retail fish market the day before the banquet. The shellfish tags had been removed before sale so that the site of harvesting could not be ascertained definitely. Investigation of the several possible sites (including beds in New York, Rhode Island, New Jersey, and South Carolina) from which the retailer obtained shellfish all revealed acceptable water standards.

DISCUSSION

Although *C. jejuni* has been recognized as a human pathogen for several decades, the organism was felt to be an unusual cause of illness until the introduction of relatively new isolation techniques.[5] In patients with diarrhea, *Campylobacter* now is isolated at the same rate as *Salmonella* and *Shigella*.[6] It is noteworthy, however, that most studies in the developed countries and all studies in the United States, to date, only rarely have found *Campylobacter* in asymptomatic control subjects (0 percent to 1.3 percent).[6-9] Thus, the isolation of *C. jejuni* from 3 of the 11 ill persons treated in this outbreak differs markedly from the prevalence of *Campylobacter* in healthy adults in the United States, and is strong evidence of *Campylobacter* as the etiologic agent.

C. jejuni is a common pathogen or commensal in many animals.[10] The majority of reported *Campylobacter* infections in humans are sporadic, without a known source. However, there now are several documented common-source outbreaks associated with ingestion of raw milk, [11,12] ingestion of chicken,[13] and contact with infected puppies.[6] Although *Campylobacter* previously has not been associated with seafood, it has been isolated from both fresh and sea water sources,[14,15] and a contaminated water supply has been implicated in one large outbreak.[16] In vitro experiments with *Campylobacter* have shown that laboratory strains of the organism survive much better in stream water at 4°C (up to three weeks) than 25°C, suggesting that cold water may be a more effective reservoir.[17] The isolation of *Campylobacter* from seawater and the evidence suggesting improved survival at colder water temperatures make clams harvested in the winter a plausible source for *Campylobacter* infection.

The clinical course of persons involved in this outbreak is consistent with *Campylobacter* infection. Reported incubation periods in other outbreaks have ranged from 1 to 11 days.[11-13] In one large series, the duration of illness ranged from one to three weeks.[6] Symptoms are similar to those reported by other investigators, although the incidence of vomiting (60 percent) was higher and the incidence of diarrhea (69 percent) was lower than that previously reported (20 percent to 34 percent and 82 percent to 100 percent, respectively).[6,9,11,16,18] Three of these studies, however, consisted of stool culture screening of patients who presented with gastroenteritis, that probably was a population more likely to have diarrhea. It may be that the size of the innoculum and the vehicle may alter the symptoms experienced, as has been suggested with other enteric infections. The fact that all but one person who ate the raw clams became ill suggests heavy contamination.

The demonstration of two different serotypes is bothersome. There has been little experience reported to date with *Campylobacter* serotyping. A recent report describes a series of six outbreaks of *Campylobacter* enteritis in which bac-

TABLE 2

Food-Specific Attack Rates for 28 Participants

	Food Eaten			Food Not Eaten		
	Ill	Not Ill	Percent Ill	Ill	Not Ill	Percent Ill
Steamed clams	9	6	60	7	6	54
Raw clams	15	1	94*	1	11	8*
Shrimp	13	10	57	3	2	60
Meatballs	10	8	56	6	4	60
Chicken	11	8	58	5	4	56
Baked ziti	14	10	58	2	2	50
Cold roast beef	6	6	50	10	6	63
Salad	12	6	67	4	6	40
Turkey	3	6	33	13	6	68
Ham	2	5	29	14	7	67
Salami	4	4	50	12	8	60
Swiss cheese	3	3	50	13	9	59
Provolone cheese	5	8	38	11	4	73
American cheese	4	4	50	12	8	60

*P=.000006 (Fisher's exact test)

tericidal and agglutinating antibodies were demonstrated in the patients involved.[19] In two of these outbreaks, there was evidence that at least two serotypes were involved.

The presence of two serotypes of *Campylobacter,* an additional *Salmonella* isolate, and failure to isolate an organism for 8 of 11 ill persons tested, raise the possibility of a mixed infection. Certainly dual infections such as acute gastroenteritis and hepatitis have been associated with contaminated raw shellfish.[20] However, the similarity of symptoms and clinical course in those persons with and without *Campylobacter* isolation supports a common etiology.

Because of the evidence implicating *Campylobacter jejuni* in this outbreak, this organism should be added to the growing list of agents that can be responsible for mollusk-associated illness. *Campylobacter* is similar to *Vibrio parahemolyticus, Vibrio cholera,* hepatitis A virus, and Norwalk virus in that it often is not detected by standard techniques used for the isolation of human enteropathogens. All these organisms should be considered in the differential diagnosis of shellfish-associated gastroenteritis.

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This space contributed as a public service.

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BRIEF SUMMARY

PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. The edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

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Please see PROCARDIA *brief summary on adjoining page*

Foodborne Hepatitis A Associated with Cheeseburgers

WILLIAM E. PARKIN, D.V.M., PAUL MARZINSKY, B.A.,
MARIE R. GRIFFIN, M.D., Trenton*

In 1979, the New Jersey State Department of Health investigated a foodborne outbreak in southern New Jersey that resulted in 24 cases of hepatitis A. Cheeseburgers ($P=0.00005$) and glorified cheeseburgers (with lettuce and tomatoes) ($P=0.004$) were statistically associated with illness. Further analysis showed lettuce ($P=0.05$) and cheese ($P=0.005$) to be independent risk factors with relative risks of 3.8 and 10.2, respectively.

Illness due to hepatitis A is one of the more common reportable diseases in the United States, with 29,500 to 35,855 cases being reported annually since 1975.[1] The Centers for Disease Control estimate that approximately 1,000 foodhandlers are reported annually with non-B hepatitis, mainly hepatitis A. From 1976 to 1979, an average of 4 foodborne hepatitis A outbreaks have been reported per year.[2] Although foodhandlers frequently are infected, they only rarely appear to transmit disease via the food they prepare.

The foods most commonly involved in foodborne transmission of hepatitis A have been those that were not cooked or those that were touched by human hands after cooking. In several instances, however, shellfish that briefly were steamed or cooked may have been the vehicle for transmission of hepatitis A.[3-6] In 1979, the New Jersey State Department of Health investigated an outbreak of foodborne hepatitis A that was associated with a cooked food not usually considered a vehicle for this disease.

On November 19, 1979, the New Jersey State Department of Health was notified that a cook in a diner in Salem County in southern New Jersey had been under a physician's care for suspected hepatitis A since his onset of illness on October 12, 1979. Four days later, two local hospitals began reporting an increase in admissions for clinically suspected hepatitis A patients. Between October 1, 1979, and December 31, 1979, 30 suspected cases of hepatitis A were reported from Salem County. Prior to October 1, only two cases of hepatitis A had been reported from this county in 1979.

A preliminary investigation of the 30 suspected cases, disclosed that two had been cooks at the diner, 21 had eaten at the diner between October 1 and October 19, and 1 ill person was considered to be secondary to a case who had eaten at the diner. The remaining 6 suspect cases either had no exposure to the diner[4] or were subsequently found not to have viral hepatitis.[2] A case-control study was initiated to identify the source and means of transmission of the hepatitis A virus (HAV) in this outbreak.

METHODS

Ill persons were asked to list friends and relatives who had eaten at the diner between October 1 and 16, 1979. These

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individuals were used as controls as were employees of a local state police barracks and their friends and relatives who had eaten at the diner in the same time period. Fifty-two controls were interviewed, as were 19 of the 21 ill persons who had eaten at the diner.

Information was obtained on frequency of eating, and dates and time of day that meals were eaten. A copy of the menu was given to all subjects with instructions to mark accordingly those food items they had definitely or probably eaten, as well as those foods they did not eat.

Interviews were conducted by members of the New Jersey State Department of Health and the Salem County Health Department. The diner was inspected by the Salem County Health Department.

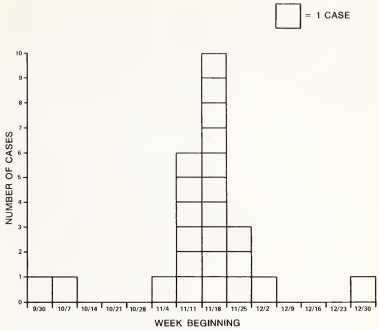
Hepatitis B surface antigen (HBsAg) testing was done on all outbreak-associated patients. Selected serum specimens on six patients were sent to the Hepatitis Laboratories Division, Centers for Disease Control, Phoenix, Arizona, for testing for IgM and IgG antibodies to hepatitis A virus (HAV).

RESULTS

Twenty-four cases of hepatitis A occurred in Salem County between October 1 and December 31, 1979, and were associated with a local diner (Figure). No additional cases were found in the adjacent counties. The two initial cases were in cooks at the diner who had onsets of illness on October 1 and 12, respectively. Onsets of illness among the 21 persons who ate at the diner ranged from November 9 through 26 while a person with a secondary case had onset on December 31, 1979. This individual had neglected to receive immune serum globulin after her husband became ill on November 13.

Ages of the 24 ill persons ranged from 14 to 72 years with over 50 percent between the ages of 25 and 50. There were 13 males and 11 females. Eighteen (75 percent) were hospitalized and there were no deaths. All were negative for HBsAg. Results of testing for HAV antibody in serum samples from the two cooks and four other patients were consistent with current (5) or past (1) infection with hepatitis A.

Cheeseburgers and glorified cheeseburgers (with lettuce and tomatoes) were statistically associated with illness. (Table). Foods containing cheese and lettuce, respectively, were significantly associated with illness. Further analysis using the Mantel-Haenszel method showed lettuce ($P=0.05$) and cheese ($P=0.005$) to be independent risk factors with relative risks of 3.8 and 10.2, respectively.[7] All 19 ill persons who completed the food preference questionnaire had eaten either cheese or lettuce. No association was found between illness and frequency or time of day meals were eaten at the diner.



Figure—Diner-associated hepatitis A cases by week of onset, Salem County, September 30, 1979, to January 5, 1980.

The first foodhandler had jaundice, stomach pain, fever, vomiting, and flu-like symptoms on October 1, 1979. His duties included that of a dishwasher and short-order cook. He prepared cheeseburgers, seafood, and steak, but no salads. He was employed at the diner the week of August 25 and September 15 through 22. He worked on and off from October 7 until he left permanently at the end of October.

The second foodhandler became symptomatic on October 12, 1979. He cooked and prepared all food items except pudding and milk. He worked regularly until October 3, took leave from October 4 to 11, worked from October 12 to 16 and again on October 18. On October 19, he left employment because of illness.

Fourteen of the ill persons and 43 of the controls were able to provide exact dates of when they had eaten at the diner. Five of the ill persons and 9 of the controls ate at the diner on a day when cook No. 1 was working and potentially

TABLE

Preference Rates for Selected Food Items
Salem County Outbreak

	Ate			Did not eat			
Food item	**Ill**	**Total**	**%**	**Ill**	**Total**	**%**	***P* value**
Glorified cheeseburger*†	5	6	83	14	65	22	0.004‡
Cheeseburger†	9	11	82	10	60	17	0.00005‡
Glorified hamburger*	3	6	50	16	65	25	ns‡
Hamburger	2	3	67	17	68	25	ns‡
Turkey club sandwich*	5	9	56	14	62	23	0.051‡
Any foods with cheese	14	28	50	5	43	12	0.001§
Any foods with lettuce	14	34	41	5	37	14	0.02§

*Contains lettuce
†Contains cheese
‡Fisher's exact test
§Chi square test

infectious ($P=0.22$, Fisher's exact test). Thirteen of the cases and 28 controls ($P=0.04$, Fisher's exact test) recalled eating there during the similar period of cook No. 2's employment.

Cheeseburgers were prepared using preformed hamburger patties, processed American cheese, and untoasted buns. A brick of American cheese was kept in the refrigerator and, as the cook needed cheese, he would use a slicer to cut the cheese, catching it in his bare hand. The cheese would be placed on a plate and kept next to the grill to be used as necessary. Thawed hamburger patties would be grilled on one side and flipped over. At this time the cheese slice would be added to the cooked side. The patty would cook less than a minute per side. The cheese would not become hot enough to lose its structural integrity. The cooked cheeseburger then would be placed in an untoasted bun and served immediately to the patron.

Lettuce was stored in a refrigerated bin. Heads of lettuce would be removed as needed and chopped up on a table by cooks or waitresses. The lettuce was placed in a large bowl and taken as needed for salads and sandwiches. Gloves and tongs rarely were used.

DISCUSSIONS

During 1979, the New Jersey State Department of Health investigated a foodborne outbreak of hepatitis A that was associated with cheese and cheeseburgers. Due to the lengthy incubation period of hepatitis A (about 30 days, with a range of 15 to 50 days), it is difficult for people to remember exactly what they ate at a specific restaurant during the time in question. For this reason, food preference histories were utilized in this outbreak to determine foods the patrons would have eaten.

Illness in this outbreak statistically was associated with a preference for cheese, cheeseburgers, and lettuce. The analysis of food preference indicated cheese to be a more likely vehicle than lettuce. Special hamburgers (no cheese but containing lettuce) were not associated with illness, while cheeseburgers without lettuce statistically were associated with illness. Cheeseburgers consist of buns, hamburgers, cheese, and condiments while hamburgers, which were not associated with illness, consisted of the same ingredients less the cheese. This indicates that the cheese was the ingredient which was the actual vehicle of transmission of HAV in the cheeseburger.

The two cooks employed at the Salem County diner had symptoms compatible with hepatitis. If their reported onset dates are correct, both prepared food in the diner during the time they would be considered infectious. Both cooks had serologic evidence of hepatitis A infection although the first cook's blood sample may have been collected too late (December) to show an IgM response. While the first cook did prepare cheeseburgers, it is more likely that the second cook was the source of the outbreak. He prepared the implicated foods (cheeseburgers and lettuce), worked at the period of peak virus excretion, and was working at the time when most persons who became ill ate at the diner.

The foods associated with foodborne hepatitis usually have been uncooked, such as green salads, guacamole, raw shellfish, and cold sandwiches.[8-10] Occasionally they have been foods that were cooked, allowed to cool, and subsequently were handled, such as glazed donuts and hamburgers and spaghetti.[8,11] Foodborne outbreaks of hepatitis A have been associated rarely with foods that have been cooked and subsequently not handled. There have been several instances in which outbreaks or cases of hepatitis have been associated with clams that were cooked or steamed inadequately.

Dismukes et al. investigated an outbreak of infectious hepatitis among four individuals who ate both raw and steamed clams.[3] The Centers for Disease Control reported an outbreak in Massachusetts in which all five cases had eaten a meal at which only steamed clams were served.[4] Mason et al. investigated a large outbreak of hepatitis due to raw oysters in which one person had not eaten raw oysters but rather oyster stew to which refrigerated, minimally cooked oysters were added.[5] Feingold reported an outbreak in which one individual developed hepatitis after eating steamed and fried clams while two of three friends developed hepatitis after eating raw, steamed, and fried clams.[6]

Snydman et al. investigated a foodborne hepatitis A outbreak in which baked scrod was statistically associated with illness.[12] However, only 36 percent of the ill persons had eaten baked scrod while 100 percent had eaten cold sandwiches which also were statistically associated with illness. In another foodborne hepatitis A outbreak, Osterholm et al. found that hot dogs were one of four food items (including ice, potato salad, and molded salmon) associated with illness.[13] No explanation was presented for the actual mechanism of contamination and transmission via the hot dog.

"The foods most commonly involved in foodborne transmission of hepatitis A have been those that were not cooked or those that were touched by human hands after cooking."

It has been shown that some HAV will survive in internally contaminated oysters in a can placed in a water bath at 60°C (140°F) for 42 minutes.[14] The oysters in the center of the can were heated to 60°C for 19 minutes. The virus will be inactivated by boiling for one minute.[15]

While the cheese was "cooked" in the preparation of the Salem County diner cheeseburgers, it seems unlikely that the cheese reached a sufficient temperature to inactivate any virus present. In the production of the processed cheese, the cheese is in a completely liquid state at 74°C (165°F).[16] Since the cheese on cheeseburgers never is liquified, the temperature cannot be expected to achieve 74°C. The cooking time of the cheese is less than one minute so a substantial proportion of virus particles present could not be expected to be inactivated.

We feel that the most likely vehicle for transmission of HAV in this foodborne outbreak was the cheese. The cheese was not heated to a sufficient temperature for a satisfactory period of time to inactivate any HAV present on the cheese. Cheeseburgers are a "cooked food" which must be considered as a potential vehicle for transmission of hepatitis A when foodhandlers are infected with the virus.

SUMMARY

In 1979, the New Jersey State Department of Health investigated a foodborne outbreak of hepatitis A in southern New Jersey. In this outbreak, 24 cases of hepatitis A were associated with a diner where cheeseburgers ($P=0.00005$) and glorified (lettuce and tomatoes) cheeseburgers ($P=0.004$)

statistically were associated with illness. Further analysis showed lettuce ($P=0.05$) and cheese ($P=0.005$) to be independent risk factors with relative risks of 3.8 and 10.2, respectively. As cooked foods, cheeseburgers usually are not considered potential vehicles for the transmission of hepatitis A. However, as the cheeseburgers were prepared at this restaurant, the cheese could not be expected to reach a temperature sufficient to destroy all hepatitis A virus present on the cheese.

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Pediatric Surgery in the Community Hospital

FRANK RATHAUSER, M.D., Lawrenceville*

Since pediatric subspecialists outnumber their training institutions, many university and community hospital staffs stand to inherit great and varied talents. Such individuals, along with modern facilities and equipment, make available to smaller communities the total pediatric care once thought limited to children's hospitals, while retaining the ever-important family proximity.

Pediatric surgery had limited availability in most areas until very recent times due to a paucity of training centers (only 15 to date in the United States and Canada), and also due to the preference of the trainee to remain comfortably situated at those "mother institutions" or to start similar sections at university hospitals that have sought to accommodate to the necessity of specialized surgical care of infants and children. In the past 15 to 20 years, many of the larger community general hospitals have become interested in subspecialists in pediatric surgery due to enforced interest by its patient load or by nonsurgical staff members who felt the need for this specialized surgery.

TRAINING

The trainee in pediatric surgical training must have a thorough background in general surgery and must be board certified prior to being accepted by one of the training centers. Broad-spectrum training in multiple fields, known as horizontal specialization, involves general, thoracic, urologic, cardiovascular, and other fields of surgery, based on age needs, rather than the vertical-type training involving single fields of surgery. After completing this training, the subspecialist usually chooses his/her own and more limited combination of fields.

The trainee must gain a thorough knowledge of human embryology and of the errors resulting in congenital defects involving one or more anatomical systems, for the correction of some anomalies frequently is emergent or urgent in order to preserve the life of the newborn. Respect for the miniature tissues involved and the need for delicate handling at all times, in order to avoid trauma and infection, is crucial. Good background knowledge of fluid, electrolyte, and acid-base balance and nutritional needs is basic.

The pediatric surgeon must have a thorough knowledge of the pathological processes that cause certain signs and symptoms in the pediatric age group but which are due to entirely different processes in the adult (Table).

HOSPITAL REQUIREMENTS

While it is easier for the trained pediatric surgeon to remain at home in his institution of training where all efforts are geared to the needs of the infant and the child, it can be an exciting adventure to bring the practice of pediatric surgery to the community hospital. Aside from the exceptional neonatal anomaly that requires treatment at a pediatric institution, it is possible to offer appropriate care in good general hospitals, where the staff has a special interest in the care of infants and children, and where some very specific staff requirements can be met. This is likely to be a

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TABLE

Pathological Processes

Symptoms	Causes in the infant and child	Causes in the adult
Esophageal obstruction	Esophageal atresia with or without tracheoesophageal fistula	Cancer of esophagus
Gastric outlet obstruction	Hypertrophic pyloric stenosis	Gastric malignancy
Duodenal obstruction	Duodenal stenosis or atresia, annular pancreas, mid-gut volvulus	Peptic ulcer disease with scarring of duodenum
Small bowel obstruction	Stenosis, atresia, meconium ileus, foreign body, mid-gut volvulus	Postoperative adhesions, tumors
Gastrointestinal bleeding	Bleeding Meckel's diverticulum, bleeding duplication	Bleeding polyp or tumor, ulcer disease
Constipation-obstipation	Aganglionic megacolon (Hirschsprung's disease)	Cancer of colon
Respiratory problems, dyspnea	Acute lobar emphysema of the newborn, requiring urgent lobectomy and resulting in cure	Chronic diffuse pulmonary disease, treated medically, increasing in severity and leading to death

slow, trail-blazing experience, starting with just part of such a staff and only some of the requirements, but where specialized personnel and equipment are added gradually. The collaborative personnel and service needs are:

Pediatricians, who are skilled and available, will apply their specialized knowledge and talents in the diagnosis and treatment of such special problems as sepsis, electrolyte imbalance, and concomitant congenital medical illnesses. Neonatologists, whose availability is increasing in general hospitals, especially are desirable. The well-trained pediatrician must be available if a section on pediatric surgery is to be considered.

Anesthesiologists must be knowledgeable about the respiratory needs of the sick infant, with special emphasis on the tiny infant pulmonary capacities, the variables in pCO^2 and pO^2, the art of intubation of tiny infants, and an alertness to the dangers of cuffed tubes. Special needs as to anesthetic agents and equipment, chemical and metabolic therapy, and acid-base balance of the newborn must be well known.

A pediatric intensive care unit for pre- and postoperative management of newborn babies and infants is indispensable.

One needs a certified laboratory with technicians who are trained in obtaining blood samples rapidly and efficiently from newborns and infants and processing laboratory samples immediately. At least one radiologist with a special interest in, and familiarity with, the unique techniques used for sick infants and children is vital to a pediatric surgery service. Included are such special procedures as carefully done barium enemas, looking for the funnel-like area of the colon in suspected Hirschsprung's disease, or the services of the interventional radiologist when reduction of an intussusception with appropropriate pressures and delicacy is needed. Such radiologists also must be familiar with the urologic tract of the newborn, where one sees double set-ups, uretero-pelvic junction obstructions, and posterior urethral valves. Accurate interpretation of thoracic studies will detect significant mediastinal shifts, cardiac malformations, and displacement of pulmonary tissue by abdominal contents in a newborn with diaphragmatic hernia.

Pathologists should be conversant with the specialized diagnostic procedures needed to recognize the presence or absence of ganglion cells in rectal or colon biopsies when aganglionic megacolon is suspected.

Specialized pediatric nursing care is an absolute must. Skilled nurses must be available to staff the newborn-pediatric intensive care unit around the clock, to provide one-to-one care wherever needed with alertness to control and/or prevent life-threatening problems.

THE TEAM

The personnel and the equipment listed previously constitutes a team effort that focuses full attention on the critically sick pediatric surgical patient. It has been the good fortune of the author to be involved in such community hospital situations. The gradual addition of trained personnel after starting out alone 25 years ago has made it possible to treat a substantial number of interesting and unusual cases, aside from the well-known neonatal problems, without referral to a university hospital center that specializes in children.

CASE REPORTS

This presentation will review a variety of gastrointestinal problems associated with bleeding, obstruction, or perforation, arising in four previously healthy patients. Our diagnostic and therapeutic approaches are outlined and some of the more important features are discussed.

CASE REPORT 1

An eight-year-old male was referred by his pediatrician after impaling himself on a metal pipe in a public swimming pool. Examination showed a small laceration of the lowermost anal canal, and intact sphincters. Admission was advised to observe for injury at higher levels. Flat and



Figure 1—Air is present beneath the liver and around the bowel.

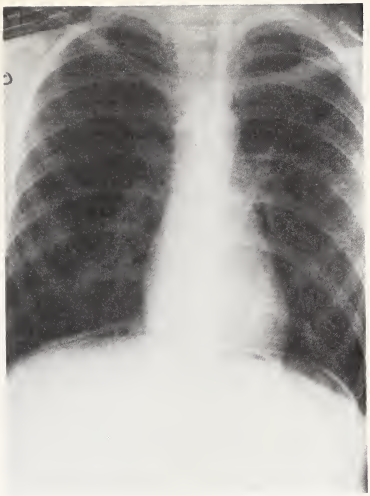


Figure 2—Air seen beneath both leaves of the diaphragm in an eight-year-old male who impaled himself on a metal pipe in a public swimming pool; examination showed a small laceration of the lowermost anal canal and intact sphincters.

upright abdominal films were ordered. Tetanus toxoid booster was given, and antibiotic therapy was begun. The patient complained of left shoulder-top pain in less than an hour. Examination of the x-ray film revealed free air beneath the liver (Figure 1) and diaphragm (Figure 2).

Blood was crossmatched and preparation for surgery was instituted by starting intravenous fluids, nasogastric suction, and continuing the antibiotic therapy. Once anesthetized, sigmoidoscopy revealed no obvious damage or bleeding. At laparotomy, an irregular perforation and a full-thickness tear of the bowel wall was seen on the anterior surface of the lower sigmoid colon. Free bloody fluid was noted on the pelvis. The entire colon and small bowel were examined to rule out damage to these structures or to contiguous mesentery or other organs, but none was found. The lacerated bowel was repaired carefully with seromuscular sutures. The upper sigmoid was exteriorized as a loop colostomy which was secured to all abdominal wall layers. After complete wound closure, the loop was divided to obtain immediate diversion of the fecal stream, and the distal limb was left as a mucous fistula. Recovery was rapid and the patient left the hospital on the seventh postoperative day.

Six weeks later, being assured of appropriate healing by prior barium study via the mucous fistula, the colostomy was taken down and the bowel repaired by a closed single-layer, Cushing-type anastomosis. The child was discharged on the seventh postoperative day, after which normal bowel habits returned rapidly, weight gain took place, and all normal activities were resumed within four weeks.

Any rectal impalement must raise suspicion of perforation at a higher level of rectum or colon and possible injury to other viscera. Close observation is imperative. Shoulder-top

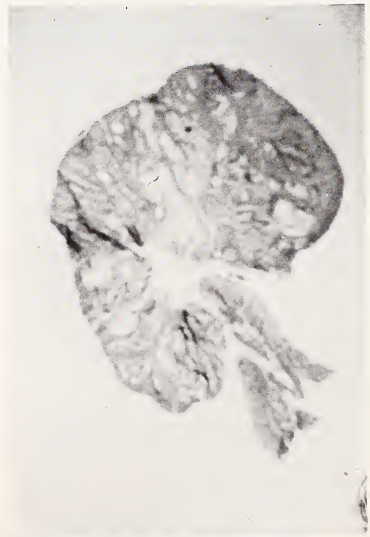


Figure 3—The resected polyp and part of its stalk.



Figure 4—The glandular outlet of the polyp easily is discernible.

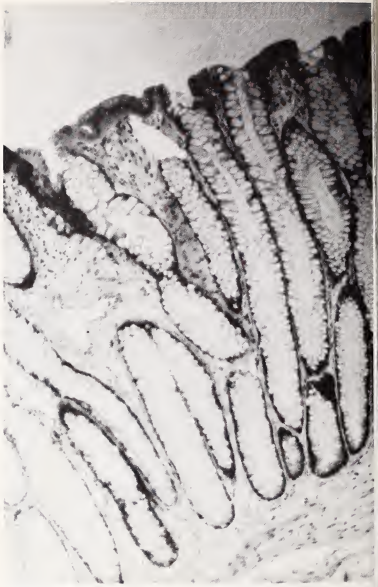


Figure 5—The mucosal lining of the pedicle is noted to be well preserved.

pain is a most significant finding and indicates the presence of free intraperitoneal air, as confirmed by erect abdominal x-ray films. Diversion of the fecal stream is mandatory in all cases of colonic injury. All colostomies in children require careful suture of the entire bowel circumference to each layer of the abdominal wall to prevent dehiscence with extrusion of the small bowel loops. Social pressures should be brought to bear to eliminate such swimming pool hazards.

CASE REPORT 2

A 15-year-old male was brought to the emergency room because of copious rectal bleeding, both free-flowing and mixed with stool. He had noted blood on his underclothes intermittently and also a change in bowel habits including frequent stools with rectal tenesmus over a period of several weeks.

Digital rectal examination brought forth a large collection of blood from the rectum, some of which was bright red and some very dark red. Bleeding from a polyp, Meckel's diverticulum, or a duplication were all suspected. Diagnostic sigmoidoscopy revealed no pathology within the lower 25 cm except for blood descending from a higher level. Emergency technetium scan for Meckel's diverticulum was negative. A barium enema was interpreted as normal but no bowel preparations had been used.

A gastroenterologist performed colonoscopy and found a polyp at 40 cm from the anus (mid-sigmoid). The polyp had a 2 cm diameter and a long stalk. It was decided not to remove the polyp by snare to avoid alteration of microscopic

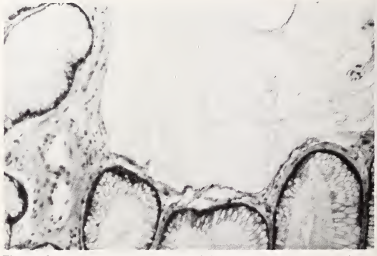


Figure 6—Retained mucoid material is seen in the stroma, along with the surrounding tissue reaction.

findings, the possibility of hemorrhage, or perforation at this high and unattached level.

Mechanical irrigation and antibiotic therapy were combined for preparation for surgery. The mass was resected through a sigmoid colotomy, and repair was done in two layers after bidirectional intraoperative endoscopy proved to be negative for other findings. Frozen-section studies showed hamartoma and this was confirmed by permanent sections (Figures 3, 4, 5, and 6).

Postoperative recovery was rapid and there have been no symptoms of recurrence. Repeat barium enema with ade-

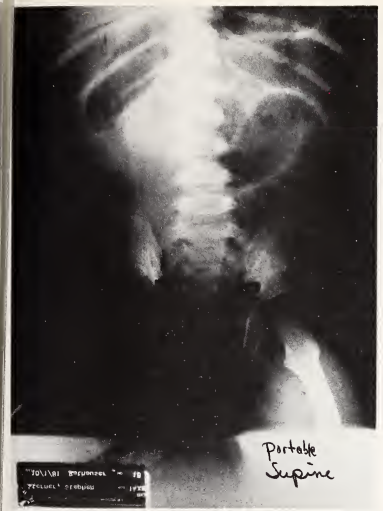


Figure 7—Flat film of the abdomen shows ileus, but no signs of obstruction.

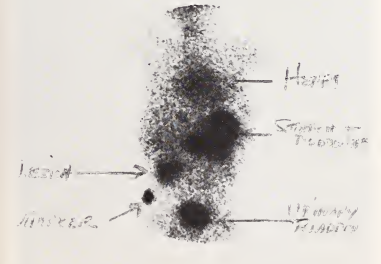


Figure 8—Note the expected acid-bearing areas picked up by the technetium, the normal areas being the urinary bladder, stomach and duodenum, and the heart. The marker is a known entity. The abnormality here is marked "lesion," and seems to be a very well-defined area, despite the perforation.

quate colon preparation was done and revealed no abnormalities.

Retrospective history, as recalled by the mother, elicited the fact that one grandparent died of carcinoma of the colon.

Not all polyps in youngsters should be considered as benign juvenile varieties that require no therapy. Solitary, large colonic polyps are not common in this age group. When found, excision is required to prevent further blood loss, to obtain appropriate diagnosis, and possibly to avoid malignant change, but when a bleeding colonic lesion is suspected, and the barium enema study is reported as negative, a second study should be mandatory after appropriate preparation of the colon. Many feel that the second study should be done by a different radiologist.

CASE REPORT 3

A 14-month-old male was referred because of gross rectal bleeding and extreme pallor. Two days previously, while standing quietly in his crib, the child had a sudden, copious, painless, bright red, liquid and clotted blood loss per rectum. He was hospitalized in another community hospital for 24 hours. Although extremely pale and irritable, despite a hemoglobin in the range of 6 gm, he had no further obvious bleeding so the infant was discharged on the following day. The mother's interpretation of this release was that the baby no longer had intussusception.

On admission to our institution, the infant was lethargic, pale, and irritable. The abdomen was soft and the rectum contained no gross blood. The hemoglobin was 6 gm. Lactated Ringer's solution was given intravenously until packed red blood cells could be prepared and transfused. The white cell count was 15,000 with a normal differential. Electrolytes were normal and the BUN of 14 was attributed to the presence of blood in the colon. Flat films of the abdomen showed significant ileus, but no obstruction (Figure 7). A technetium scan was positive for Meckel's diverticulum (Figure 8). At surgery there was a mixture of blood and small bowel content in the peritoneal cavity. The source was a bleeding and perforated Meckel's diverticulum. The very wide base of the Meckel's diverticulum necessitated a sleeve-resection of ileum containing the attached lesion. A single-layer, Cushing closed anastomosis was done.

Nasogastric suction was continued, and blood counts and electrolytes were monitored. It became evident after a few days that bowel function had not progressed as expected and the abdomen remained quite distended. The total protein was low (4.9 gm); fresh frozen plasma was infused to raise the serum protein level and improve function at the anastomotic site by reducing local edema. Within a day there was dramatic improvement; repeat x-ray films on the sixth postoperative day showed a reasonably normal gas pattern. Following digital examination, a copious stool was extruded and the abdominal girth decreased by 4 inches. He ate well and had daily bowel movements. Two days later, the infant was discharged in excellent condition. Since then, reexamination and a postoperative small bowel x-ray study revealed some residual clumping of barium in the right mid-flank, thought to be due to extrinsic adhesions. The infant remains completely asymptomatic.

Although copious blood loss can occur with intussusception, one also would expect obstruction plus a palpable mass, both of which were absent. The differential diagnosis included bleeding from a Meckel's diverticulum, a duplication, or a polyp. Technetium scan with the new gamma camera is an excellent way to diagnose Meckel's diverticulum.



Figure 9—Upright film of abdomen shows the expected fluid-air levels in intestinal obstruction.

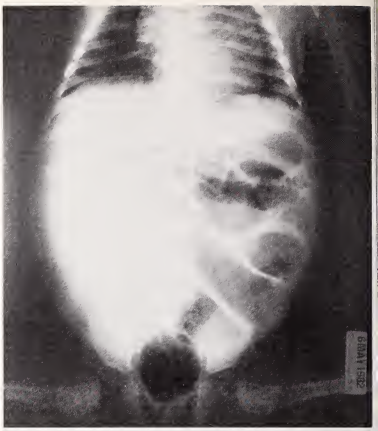


Figure 10—There are numerous dilated small bowel loops in the abdomen. Note the comparative absence of air in the right lower quadrant.

Meckel's diverticulum should be considered in any case of rectal bleeding. The concept that babies do not bleed to death from Meckel's diverticulum is a dangerous one. Blood loss can be quite severe and require replacement transfusions that may be lifesaving.

This very sick infant's bleeding was recognized but specific signs of peritoneal irritation secondary to perforation were absent completely or overlooked because of his lethargic response to external stimuli. Perhaps this may be compared to the very sick infant with meningitis who, although deep in shock and showing a mottled skin, demonstrates no stiff neck.

Closed anastomoses work well in the intestinal tract of the infant or child. Cautery is used to seal off vessels at the site of bowel-crushing clamps. It avoids spillage into the peritoneal cavity. One must be careful to open the sealed edges of the bowel after completion of the anastomosis.

CASE REPORT 4

A three-month-old female infant was admitted directly to the hospital from the pediatrician's office because of profuse rectal bleeding and vomiting of bilious and stool-like material for two to three days. The infant was severely lethargic and barely responded to stimuli. The mother described severe diarrhea over several days after the onset of illness. The infant screamed frequently and simultaneously pulled her legs up onto the abdomen.

Examination of the right side of the abdomen revealed a palpable mass that was thought to be due to ileocolic intussusception. This was confirmed during bimanual abdominal and rectal examination, but there was no blood in the rectal ampulla. Preparation for surgery was started with

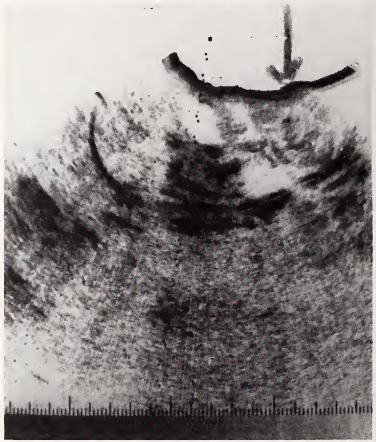


Figure 11—The mass is well seen on the ultrasound study, at the position of the arrow.

intravenous fluids, a transfusion of 60 cc of packed red cells, and institution of nasogastric suction.

Flat films of the abdomen showed fluid levels (Figure 9) and dilated small bowel loops (Figure 10). Ultrasound study of the abdomen confirmed the presence of the suspected mass (Figure 11). A barium enema was done after the infant became more reactive. We expected to see an intussusceptum in the ascending colon or a mass emanating from the pelvis.



Figure 12—Barium enema study shows the high cecum expected in an infant, but filled completely with barium, thus ruling out involvement of the colon in the process of intussusception.

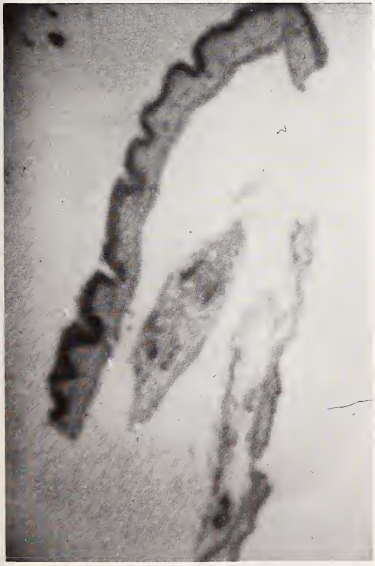


Figure 13—Part of intussusceptum and hemorrhage in the intussuscipiens.

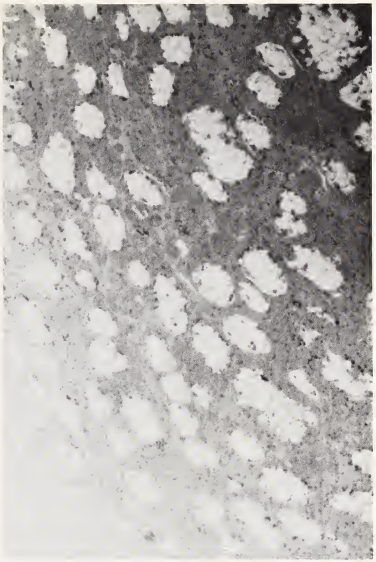


Figure 14—Section of the tubular adenomatous polyp with intense hemorrhage and necrosis.

Surprisingly, a normal ascending colon and cecum could be filled with barium but it was not possible to reflux the barium into the small bowel (Figure 12). The sausage-shaped mass remained palpable.

Because of the persistence and position of the mass, a diagnosis of incarcerated ileo-ileal intussusception, thought to be secondary to an inverted Meckel's diverticulum acting as a leading-point, was made. Intravenous therapy and nasogastric suction were continued; extra units of packed cells were placed on reserve for use in the operating room.

At laparotomy, which was performed as soon as the infant became fully hydrated, an incarcerated, strangulated ileal mass was resected and a Cushing closed anastomosis was done. A feeding gastrostomy tube was inserted for decompression. The resected specimen measured 67 cm in length and consisted of an ileo-ileo-ileal intussusception (Figure 13). It exhibited a lead-point of a hemorrhagic, necrotic polypoid mass attached to the bowel 7 cm from the proximal cut end. The polyp measured 3 cm in length and almost was infarcted totally (Figure 14). The mesenteric vessels in this resected specimen were thrombosed entirely. The intussusceptum wall showed hemorrhage and necrosis (Figure 15) as did the wall of the intussuscipiens (Figure 16).

Recovery was rapid and the infant left the hospital on the 7th postoperative day with the gastrostomy tube in situ. Changes of dressings were done as office procedures, and it never was necessary to open the tube for decompression at home. The tube was removed on the 18th postoperative day; the infant ate well, had normal bowel movements, and gained weight rapidly.

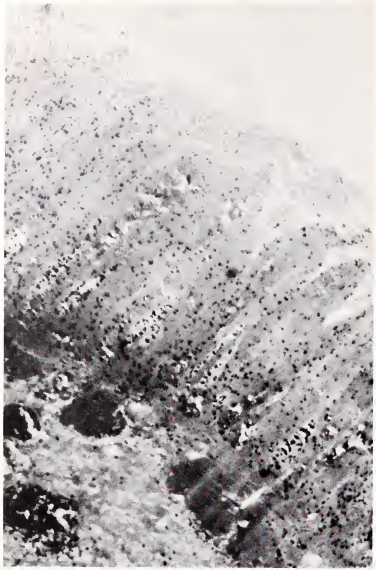


Figure 15—Wall of intussusceptum showing hemorrhage and necrosis.

Any gastrointestinal polyp may bleed, obstruct, or act as a lead-point in intussusception. A most unusual feature was the lack of involvement of the colon as an intussuscipiens for the telescoped small bowel segments. A typical sausage-like mass was palpated easily in the ileum, in a direction similar to that expected to be found if the colon were involved. This surprising finding was confirmed only with the help of a barium enema. In such long-term intussusceptions, one would expect to see blood per rectum, but it must be presumed that the blood was trapped cephalad to the ileocecal valve by the very large mass of intussuscepted bowel impinging itself here. Although large obstructing polyps of small bowel are rare in infants, one must always suspect such a possibility.

A technetium scan is helpful in locating a Meckel's diverticulum and ultrasound studies may help in locating a

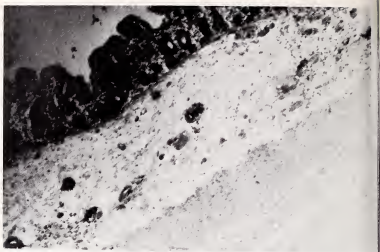


Figure 16—Wall of intussuscipiens showing marked edema and also hemorrhage and some necrosis.

mass. These studies are not traumatic and may be performed simultaneously with correction of dehydration and electrolyte imbalance, transfusion of packed cells where needed, and institution of antibiotic therapy in preparation for laparotomy. Technetium scan was omitted here because of lack of obvious bleeding.

A feeding gastrostomy is useful in infants and children, for decompressive purposes, when the peritoneal cavity has not been soiled because infants and children tolerate nasogastric tubes very poorly. Later, such tubes may be used for feeding in long-standing nutritional problems.

SUMMARY

Certain critical neonatal surgical problems, like diaphragmatic hernia, might preferably still be referred to distant specialized pediatric centers. On the other hand, many serious or even life-threatening problems, including many neonatal conditions, like duodenal atresia or tracheoesophageal fistula, now are treatable at certain select university or community hospitals. These special institutions have taken it upon themselves to acquire the necessary modern facilities, along with the latest equipment and the skilled staff needed in putting them to good use. Well-trained pediatric medical, surgical, anesthetic, intensive care, neonatal, nursing, and laboratory specialists must work as a team which plays so vital a part in the total care of the critically ill child.

Some pediatric surgeons, particularly those remaining affiliated with the training "mother institutions," hold to the belief that these few centers should take care of the entire gamut of pediatric surgical problems. Others, with equal training, find new territories to conquer by offering their vitally needed expertise in areas previously considered pediatrically barren.

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COMMENTARY

Consequences of Living in a Hair-Trigger Alert Era

DONALD B. LOURIA, M.D., Newark*

We are moving into a new era of international nuclear tensions. This era, scheduled to arrive in 1984 or 1985, will be dubbed the hair-trigger alert and may have major deleterious effects on the family, the use of drugs, and the environment.

Today the public issue that increasingly dominates our thinking is the threat of nuclear holocaust. There are those who believe fervently that we have remained at peace since the close of World War II because of a mutual balance of terror between the Soviet Union and the United States. According to this hypothesis, war will break out only if one side or the other gains or believes it has achieved a superiority, that it can take a chance on a first strike against the other side's land-based missiles without the likelihood of incurring massive retaliation.

Those who accept the validity of this concept believe that the only way to assure continuing peace is to build a greater and greater deterrence so the Soviet Union never will dare to attack us.

The argument that peace can be maintained by increasingly grotesque arsenals must be viewed skeptically; our technologic achievements are so extraordinary that each new generation of weapons makes the world a more threatening place in which to live. When in place in Europe, our Pershing II missile will be able to strike targets in the Soviet Union in about six minutes. Weapons such as the cruise missile are so smart they give us first-strike capabilities, compel equal technologic advances by the Soviet Union, and paradoxically lessen our security and destroy our tranquility.

After World War II, the brief iron curtain era blended into a much more prolonged cold war. The obvious antithesis of a cold war is a hot war. If we continue to arm ourselves with weapons that can decide the survival of a nation in a war that would last only a few hours and if the decision to start such a war may have to be made within a five- to ten-minute period from a given inciting event (e.g. a report of a Soviet missile on its way to the United States) then we soon shall be entering a new era that no longer can be correctly categorized as a cold war. We and the Soviets, armed to the teeth and spouting belligerent rhetoric, will be compelled to be on even more critical alert 24 hours a day, 365 days a year—prepared to launch our weapons in a flight that likely would result in the total destruction of the Soviet Union, Europe, and the United States. This will be the hair-trigger alert era and roughly one billion people will have to live under the constant, wrenching concern that one miscalculation, one act of stupidity, one bureaucratic mistake could mean the end of our families, our society, and our nation.

Make no mistake about it. The hair-trigger alert era is just about here. Unless something changes, it will be a fact of life by the end of this decade, and perhaps much earlier.

Once the adults and, more importantly, the young—teenagers and young adults—comprehend the perpetual terror of the hair-trigger alert era and if simultaneously they believe there is no impending solution, that they will have to live their entire lives under the threat of immediate annihilation, inevitably they will become convinced we no longer are a meliorist world—that is, we cannot solve the critical problems facing our planet by the dint of our own efforts. They will believe we are a fey society, doomed to destruction and desolation. This never has happened. We always have been warned about the ravages of overpopulation, dwindling sources of energy, loss of planetary oxygen by destruction of

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the rain forests, devastation of the environment by pollution, melting of the polar icecaps from pollution-induced greenhouse effect, and massive starvation because of inadequate food supplies. We accepted these warnings as hyperbolic delineations of major problems that we would have to face and solve; but we never thought any of these was insoluble. Man made these problems and the ingenuity of man would solve them. The threat of nuclear warfare is different. It is the superordinating issue of our times. It is monstrous technology out of control, and it threatens our meliorism. Equally important, it threatens the perception that we are a society that believes the world tends to become better and that man has the power to aid its betterment.

The threat to this perception of meliorism partly will come from the hair-trigger readiness of the Soviets and the United States. It will be augmented profoundly by the realization that although the danger of catastrophic retaliation may hold the Soviets and Americans in check, all-out nuclear warfare well may result from something other than a deliberate attack. The most likely possibility is some sort of accident or mistake. It boggles the mind to think that we who have with justification trumpeted the virtues of our own democratic system and denigrated the accomplishments and efficiency of the Soviet oligarchy now are dependent entirely on their flatulent bureaucracy for our survival. Even if we are reasonably confident that our bureaucracy has enough checks in the system to avoid an accidental holocaust, surely we cannot trust the Russian bureaucracy. One stupid mistake is all that it would take in a hair-trigger alert era.

Other potential starting points for Armageddon include escalation from a local war, intentional actions of a third power, or the actions of political terrorists. Think what might have happened if Argentina and England had played their potentially lethal war games over the Falkland Islands in 1990 when both had nuclear weapons and nuclear bombs. The potential scenario would be no different from sequences that have occurred in United States-simulated war games. Argentina would call the English "bluff" and send a ship or plane to test the British resolve. The British would sink that ship or shoot down that plane with conventional weapons. With national pride and fears of an angry reaction by the people of Argentina, the Argentine military hegemony decides to sink one British ship with nuclear weapons launched from a plane. They succeed. England says they can play the same game and destroys a major military installation with a submarine-launched nuclear attack. Argentina then launches more nuclear weapons, and England retaliates; Russia and America choose different sides—and we are off.

Contrary to many pronouncements, a nuclear exchange between the United States and the Soviet Union would not necessarily destroy the world. The Soviet Union, the United States, and Europe surely would be obliterated and made uninhabitable because of residual radiation. The southern hemisphere—Africa, South America, parts of China, and India—would receive enough radiation to increase the incidence of birth defects and cancer, but they might survive. (This assumes the ozone layer would not be as badly depleted as predicted; if the ozone layer were reduced markedly, virtually every living creature that sees and is exposed to the sun would become blind, except man who could wear protective glasses.) A tyrant, idealogue, religious fanatic, or madman in a third nation, unconcerned about possible ecosystem destruction, might be tempted to eliminate the world's two major powers by sending a missile to each country to trigger an all-out war or achieve the same nefarious goal by sabotaging both countries' computer systems in order to convince each that the other country had just initiated an attack.

If the Russians and Americans continuously build up their already massive nuclear destructive capacity, can they simultaneously urge, even attempt to mandate, that other nations not develop such capacity? It is the apogee of arrogance. Surely other nations will develop such capacity for use in their own political posturing and maneuvering. By 1990, 20 or 30 nations will have nuclear weapons and nuclear bombs. By 2020, the number well may swell to 50 or 80. Eventually, most of the nations of the world will be able to start a nuclear holocaust and there will be ample reason for people to be convinced that this world is doomed to suffer the ravages of a massive nuclear war and that the 2 countries that definitely will not survive are the United States and the Soviet Union.

POTENTIAL CONSEQUENCES

If this state of mind should develop and if the young people of our society are convinced that they have no future because this problem is unsolvable, then I believe a series of consequences will occur that will rend the fabric of our society, even if actual war never occurs. They are as follows:

First, there inevitably would be a massive reduction in goal-directed activity. If there is no future there is no rationale for planning for one's own future or for the future of one's children or spouse. A preliminary study by William Beardslee, M.D., and John Mack, M.D., conducted from 1978-1980 suggests that children already are changing their

"The Dark Age may return. The Stone Age may return on the gleaming wings of science and what now might shower material blessings upon mankind may even bring about its total destruction."

perceptions of and plans for the future because of fear of a nuclear holocaust.[1] Young people would feel no necessity for settling down relatively quickly and would be much more inclined to spend up to five to ten years after finishing their education wandering around enjoying themselves, uninterested in commitment, satisfied with menial tasks or ephemeral employment that is accepted only to obtain enough money to continue pleasure-seeking. Increasing numbers would not bother to seek higher education opportunities and especially those who are less affluent increasingly would not even bother to complete secondary school education. Others would continue to seek material acquisitions that would be used for immediate gratification; there would be no inclination to save for the future since the accepted notion would be that there will be no future. This country would be thrown into economic chaos. Societal productivity would fall profoundly. More and more persons, unprepared for emergencies (such as prolonged acute medical sickness or even the problems accompanying the aging process) would have to be supported by society. Even if there were to be no war and the above scenario occurs, society will inevitably lose vigor and will become far less able to compete

internationally; more competitive countries, including some emerging nations, would become dominant, relegating the United States to a position of a second-rate power, influential not because of its accomplishments or its economic strengths, but solely because of its armaments.

Second, young people would be less inclined to participate in the solution of the major nonmilitary problems facing our society that ordinarily are attacked by a combination of political actions at a federal, state, or local level, by philanthropic contributions, and by private activities at a community level.

Winston Churchill said "What is the use of living if it be not to leave this world a better place to live in after we are gone?" If there is no future, it is impossible to leave the world a better place in which to live, so there is no need to concern oneself with constructive activities. That, in turn, means that major problems facing our society—inner city deterioration, a burgeoning older population, world hunger, the depletion of energy resources, unemployment, and a technological explosion unfettered by humanistic considerations—would be allowed to fester with no innovative and effective solutions.

Thirdly, the rejection of goal-directed activities and indifference in regard to major problems would be particularly critical in regard to despoiling our environment. There would be no determination to maintain forests by replacing trees, no concerns about the killing of lakes with acid rains, no worries about dumping toxins into leaking landfills, rivers, or oceans. Convinced that at least the northern hemisphere was doomed to destruction, why would it matter if our air was seriously polluted, our water supply contaminated, or our lakes dying?

So long as the air pollution and the water contamination with chemicals did not cause acute illness, who would care about slowly developing diseases such as pulmonary emphysema or cancer? So long as there were ample swimming pools, why worry about the gradual destruction of the oceans and rivers? We would assume we could use up all our resources without regenerating them or protecting them for soon the greatest poison of them all, radiation, would make the northern hemisphere virtually uninhabitable. George Bernard Shaw said, "We are made wise not by recollections of our past but by responsibility for our future." If the perception is that there is no future, there will be no feeling of responsibility for that future. Any civilization that hopes to survive must operate, at least in part, on the premise that what it does in a given generation is predicated to a considerable extent on concern for future generations. If we become convinced there will be no future generations then one of the basic tenets upon which our civilization is built will be shattered.

Fourth, there will be almost a monolithic focus on pleasure and hedonistic materialism and that, in turn, would almost guarantee a drug scene that would dwarf anything that exists today. Two of the major reasons for drug use are the search for pleasure and the influence of the peer group. All the illicit drugs, including heroin, cocaine, and marijuana, are capable of initiating or augmenting feelings of pleasure and contentment. The same is true of our legal intoxicants, such as alcohol. If there is a massively increased focus on pleasure, then anything that enhances pleasure will be embraced. People will take any and every drug available to them, legal or illegal, more dangerous or less dangerous, in the search for pleasure and to avoid facing an awesome and Stygian reality. People will be using these drugs alone or in groups, morning and night, regardless of the potential consequences. "Live for today, for tomorrow we die," will be a societal motto. If there is no tomorrow, then people will want to enjoy the pleasures of today. And it won't just be the teenagers and those in their 20s or 30s. The very young, the middle-aged, and the elderly will join a frantic search for escapist pleasure. The excessive and indiscriminate use of mind-altering drugs will become a dominant characteristic of society.

"We must never relax our efforts to arouse in the people of the world and especially in their governments an awareness of the unprecedented disaster which they are absolutely certain to bring on themselves unless there is a fundamental change in their attitudes toward one another as well as their concept of the future."

Fifth, a casualty of the conviction that there is no future surely will be the family. At present, about one of two marriages ends in divorce or separation. If there is a focus on pleasure rather than goal-directed activities, then there will be a reduced desire to get married and have children. Young people will not want to accept increased responsibilities. Furthermore, if parents spend a progressively greater amount of their time in hedonistic activities of their own, they will spend less time devoted to the proper upbringing of their children and this will further weaken family bonds. La Rouchefoucauld noted, "There is nothing so infectious as example."

Sixth, there might well be escalating personal violence because of reduction in constraints that are imposed by a reasonably stable and well-functioning society. If the society perceives itself as doomed, a breakdown in such restraints is inevitable. Many persons who are persuaded there is no future will take all sorts of risks, including violent behavior. Furthermore, some of the illicit drugs that will be used increasingly, including cocaine and amphetamines, are notorious in their propensity to augment aggressive behavior in certain individuals. Additionally, the tensions of everyday life for people living under the constant threat of annihilation will increase individual aggressive reactions in some persons who are unable to cope with anxieties that are either created or augmented by the world situation.

Alternatively, some persons, unable to cope with the growing violence around them, would use illicit drugs such as hashish, heroin, and LSD that have the capacity to effect a virtual withdrawal from reality and from the traumas of the external world. Others, upset by their own anxiety-induced enhanced aggressive proclivities, would use these same drugs as a mechanism of coping with these emotional problems.

Thus a hair-trigger alert era would establish a milieu in which the peoples of the involved countries might well become convinced they were living in a nonmeliorist era. This would create in the United States a nation of hedonists, unconcerned about the future, the environment, or the family. We would become, in essence, futilitarians—living

from day to day with no pride in the past and no hope for the future.

One of the problems of depicting this mordant, feral scenario is that its very description is anxiety-producing and this, in turn, tends to exacerbate the problem and even initiate some of the problems I have envisioned for the hair-trigger alert era.

It is necessary to alert the public, no matter how painful the description of life under the threat of imminent nuclear annihilation. If people are alert to the horrible consequences of unrestrained chronic nuclear confrontations, then a concensus can be established to force world political leaders into actions to reduce tensions and minimize the chances of accidental or intentionally initiated holocaust. Leaders must be made to realize that the threat of nuclear war in the absence of actual war can have its own catastrophic effects.[2]

Albert Einstein said, "We must never relax our efforts to arouse in the people of the world and especially in their governments an awareness of the unprecedented disaster which they are absolutely certain to bring on themselves unless there is a fundamental change in their attitudes toward one another as well as their concept of the future. The unleashed atom has changed everything except our way of thinking."

We must alter our thinking, change our patterns, and take new initiatives. The arms race, the lethal nuclear leapfrog we have been playing, has not succeeded and cannot succeed except in the short run. In the long run it can only lead to our destruction. I believe we can pull back from the abyss.

SUGGESTIONS

The following are four suggestions that I believe are the foundation for nuclear sanity and for a safer world that can believe in its own future and can attend to other critical problems. These four are part of the program for prevention of nuclear war developed by the Northern New Jersey Chapter of Physicians for Social Responsibility.

1. It is imperative that the peoples of the world know the facts about our relative strengths. There are so many conflicting reports from our own government that it is impossible to know where we stand. The Russian leaders never have to tell their people anything. If it turns out that the two nations are about at parity, then there can be no excuse for a continued arms buildup. I would propose that an ad hoc unit or an existing unit external to both the United States and the Soviet Union (such as the International Institute for Strategic Studies in London) be asked by the two super powers to make a detailed analysis in simple language of the military strengths of the two nations. The Soviet Union and the United States would have to agree that the study would be made available, unmodified, for distribution on radio and television and in newspapers and bookstores.

2. There must be continuous and persistent negotiations with the Soviet Union about total arms control and mutual symmetrical disarmament. It is inappropriate and dangerous to refuse to undertake such negotiations until we have achieved superiority or at least our own definitions of parity (which others see as a blatant drive for superiority). Continuous serious negotiation is one way to avoid misinterpretations and subsequent conflict. Thus far, we are substituting puffery, rhetoric, and public relations pronouncements for real negotiations. We intentionally are not negotiating about weapons research, development, and testing, or about avoiding combat in space.

In this regard, we do not need bigger weapons to create incentives for the Soviets to negotiate arms reduction seriously. We have such a weapon: the Cruise missile—destabilizing, small, powerful, and accurate. I think our government is aware of this reality. Furthermore, if we are permitted to deploy these weapons in Europe the destabilizing effect will be so profound it will make the task of the arms control negotiators infinitely more difficult.

3. Following Einstein's precepts, we should change our behavior patterns in regard to our present efforts to reduce nongovernmental communications with the Soviet Union. We should increase our cultural, scientific, athletic, and social contacts with the Soviet Union. Bilateral extensive exchanges at every level are perhaps the best preventive medicine. Give people a chance to talk together, work together, play together, and compete together on friendly terms and we will get along.

4. We might try some innovative reversals in policy. For example, the Russians want to build a pipeline to western Europe for their natural gas to improve their economy. We did everything we could to prevent this and force our allies not to participate. If we prevent the Russians from exporting their energy surplus in natural gas they might just retaliate by trying to interdict an energy source we need, or alternatively they might attempt to get control of it. Why not dare to think differently? What about trying to see what happens if we help the Russians build their pipeline. That may appear to some to be outrageous heterodoxy but surely it is worth giving real cooperation a chance. The precise actions are less important than starting to change our rigid way of thinking in the hope they change their rigid way of thinking.

Einstein warned us. Truman warned us. Eisenhower warned us. Churchill said, "The Dark Age may return. The Stone Age may return on the gleaming wings of science and what might now shower material blessings upon mankind may even bring about its total destruction. Beware I say. Time may be short."

CONCLUSION

The nuclear holocaust issue is the dominant issue of our times. What is at stake is the survival of our children, of our society, and of our world. I am convinced we are still meliorist. We can decide our future. But if we want that future we do not have much time; there is very little leeway. We must demand that our leaders pull back from the abyss, that they move now towards nuclear sanity. We must create a veritable tidal wave of world public opinion that will engulf the Soviets and other world leaders in the movement towards a more peaceful and less threatened world. And we must do it now. Let us insist on nuclear sanity for ourselves, but even more for the sake of the unborn children of this beleaguered planet.

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CASE REPORT

Abdominal Distention Syndrome in a Patient Receiving Cimetidine-Nortriptyline Therapy

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A patient, treated with cimetidine and nortriptyline, gradually developed abdominal pain and distention. These gastrointestinal problems rapidly remitted after the medication was discontinued. A brief literature review suggested that both tricyclic drugs and cimetidine produce blockade of H_2 receptor sites. Caution is recommmended with the combined use of cimetidine and tricyclics because of this previously undocumented problem.

During its relatively short history of availability to physicians, cimetidine (Tagamet®) has proved to be remarkably effective in the treatment of ulcer and gastric distress. Tricyclic antidepressants, such as nortriptyline (Pamelor®, Aventyl®), have been demonstrated to be effective in depressed patients over the longer history of their use in medical practice. The patient in this report displayed symptoms that appeared likely to respond to these medications, however, their combined use resulted in a surprising though rapidly reversible problem.

CASE REPORT

Our patient is a 45-year-old white woman who regularly was treated for a depressive disorder since June, 1980. She had been treated by her internist for two years prior with imipramine in the dosage range of 225 to 300 mg daily with some improvement. After psychiatric consultation, treatment initially consisted of continued imipramine therapy and weekly individual psychotherapy sessions aimed at improving the patient's insight. Due to persistence of symptoms, including fatigue, bouts of crying, irritability, lowered mood, and frightening dreams, I changed her medication to nortriptyline 100 mg daily, in February, 1981. These symptoms improved somewhat in the subsequent weeks. Over this period of time, she was involved actively in divorce negotiations and plans for a career change. In April, she began to experience stomach discomfort between meals that temporarily was relieved by an antacid. She had no history of gastrointestinal disorder. Approximately one month later, her epigastric pain gradually returned so a medical consultation was suggested. In June, 1981, she was seen by her internist, who felt she was experiencing gastritis associated with hyperacidity. He prescribed cimetidine 300 mg q.i.d that brought about rapid and total relief of her pain. In August, she noted the return of occasional epigastric pain, which worsened over the next four weeks and was accompanied by increasing nausea, anorexia, and abdominal distention with diffuse tenderness to palpation. She denied dry mouth, constipation, blurred vision, or urinary retention.

Plain abdominal film revealed no abnormalities. Upper gastrointestinal series showed gastric dilatation with delayed emptying; retained secretions and food were noted in the stomach. Nortriptyline was discontinued without effect on her gastrointestinal symptomatology over the subsequent 48-hour period. Cimetidine then was discontinued with subsequent rapid disappearance of these findings over the next 48-hour period. One year later, she is free of gastrointestinal symptoms. Her only medication is diazepam (Valium®) 15 mg daily.

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DISCUSSION

This patient's experience initially may appear as an unfortunate result of the use of two different drugs used for two different disorders. On closer observation, however, we may discover some interrelationships between the disorders and their treatments. Certainly the patient was chronically depressed and more acutely anxious, due to the stress of marital and vocational crises. The emergence of acute gastritis to compound her basic depressive disorder hardly seemed surprising and it warranted specific treatment.

We know that cimetidine is a histamine H_2 receptor blocker; however, the fact that tricyclic antidepressants also possess this activity does not seem to be appreciated by clinicians and is not clearly documented in the literature. Over thirty years ago, when imipramine and its congeners first became available, they were classified as antihistamines. Since then, H_2 receptor sites have been discovered and more specific research efforts have become possible to determine both the site and the mechanism of drug activity.

In 1980, Tuong and his associates in France demonstrated what they described as extremely potent H_2 receptor antagonism by tricyclic antidepressants, leading them to suggest that this property might represent the molecular basis of clinical antidepressant activity.[1] Norwegian investigators have demonstrated that tricyclic trimipramine has antiulcer effects equivalent to cimetidine.[2] Polish researchers have found cimetidine, imipramine, and amitriptyline to be equally effective in the reversal of hypothermia which had been induced in rats by dimaprit, an H_2 receptor agonist.[3] In a more recent Norwegian study, Hoff et al. reported no significant differences between cimetidine and doxepin in ulcer healing in matched groups of patients.[4]

CONCLUSION

Additional investigation will need to be done to elucidate further the links between these compounds. Fortunately, our patient's problem was recognized early and discontinuation of the medication resulted in rapid improvement. Despite the limitations of our knowledge, I feel that caution is warranted in the combined use of tricyclics and cimetidine due to their apparently overlapping blockade of H_2 receptor sites.

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CONTEMPORARY CLINICAL NUTRITION

Analysis of Vitamin Status

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The relationship between subtle human diseases and vitamin deficiency still is to be determined. Many clinical conditions however warrant accurate vitamin assessment now. Newer techniques of vitamin assay using protozoa provide a sensitive and specific method for quantitative determinations of vitamins in body fluids and tissues. Wider use of this technique is recommended.

When some diseases first were recognized as deficiencies of one or another metabolite, vitamins were measured by their effect as supplement to a basal diet upon the growth and health of one or another laboratory animal. Vitamins are organic molecules required in minute quantities whose effects are based not on caloric value but on catalytic activity. Elucidation of their structure, followed by industrial syntheses are exciting chapters in microbiology and organic chemistry; their identification as prosthetic groups of enzymes fulfilled the revolution in biochemistry initiated by Sir Frederick Gowland Hopkins.

Many diseases involve vitamin deficiencies because of faculty absorption, transfer, or utilization. Because the vitamins are components of indispensable coenzymes, such functional deficiencies can be a serious sequel of malabsorption, where the picture often is one of multiple deficiencies. The same holds for many anemias. In many other diseases where the deficiency is second to other pathologic events, multiple deficiencies can contribute to the gravity of the diseases.

The recognition of vitamin structure permits their determination by the tools of analytical chemistry. Although such methods are used widely to monitor industrial production, the minute quantities in body fluids and tissues limit the chemical approach to a few members of their groups: vitamins A, C, D, and E.

Since vitamins, especially the water-soluble ones, enter into the coenzymes for fundamental cellular mechanisms, several are required by invertebrates and by unicellular organisms, such as bacteria and protozoa. One has a wide choice of microbes for the assay of vitamins.

VITAMIN ASSAYS AND THEIR NEED

Microbiological assays for vitamins should emphasize correlation with clinical findings; high precision is of secondary importance. Before introduction of microbiological assays for B_{12} in human serum, deficiency could be detected only by hematological stimulation upon administration of liver extracts or crude B_{12} concentrations and folic acid. Because folic acid is related metabolically to vitamin B_{12}, microbiologic assays had to be devised for differentiating the megaloblastic anemias. Through the use of protozoan reagents, this has been solved not only for the B_{12} folic acid duo, but also for thiamin, biotin, pantothenic acid, riboflavin, nicotinic acid, vitamin B_6, and a differential assay of folates generally. Coupled with micro-chemical techniques for determining vitamins A, E, C, and carotenes, these additions to the diagnostic armamentarium have proved their clinical worth for assaying these vitamins in biologic fluids and tissues;[1,2] these techniques are in current usage at the New Jersey Medical School University Hospital.

Protozoa, micro-animals, are used to assay all but one B-vitamin; folates are differentiated by bacterial assay.[2,3] Use of protozoa is not as well known, for historical reasons, as use of bacteria or fungi. Protozoan assays have advantages over other biological, physical, or chemical assays. These include unusually high sensitivity and a vitamin specificity that mimics humans. Because of their ability to obtain exogenous metabolites by endocytosis, i.e. phagocytosis and

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TABLE

*Clinical Conditions Warranting Vitamin Assessment**

1. Vitamin B_{12}

Macrocytic anemia (differential diagnosis)
Malnutrition
Surgery to stomach and small bowel

2. Folic Acid

Macrocytic anemia (differential diagnosis)
Neurologic involvement
Alcoholism
Liver disease
Gastrointestinal disease and surgery
Food fadism
Drug abuse
Sprues
Pregnancy

3. Vitamin B_6

Microcytosis with normal iron
Neurologic signs, e.g. convulsive seizures
Peripheral neuropathy
Malnutrition
Alcoholism
Liver disease
Pregnancy

4. Thiamin

Cardiomyopathy
Neurologic involvement, e.g. peripheral neuropathy
Alcoholism
Malnutrition
Liver disease
Drug abuse

5. Niacin

Malnutrition
Dermatitis
Diarrhea
Dementia

6. Biotin

Seizures of unknown origin
Food fadism

7. Riboflavin

Glossitis and cheilosis
Hypervascularity of conjunctiva
Scrotal hyperemia

8. Pantothenic Acid

Neurologic involvement, e.g. "burning feet syndrome"
Alcoholism
Liver disease

9. Vitamins A & B-carotene

Xerosis
Liver disease
Malnutrition
Dermatitis
Gastrointestinal surgery
Intestinal disease

10. Vitamin C (ascorbic acid)

Gum lesions
Ecchymosis
Petechiae
Scurvy, e.g. corkscrew hairs
Malnutrition
Hemolytic anemias
Gastrointestinal disease

11. Vitamin E

Liver disease
Hemolytic anemias
Gastrointestinal disease
Cystic fibrosis
Steatorrhea

*A complete vitamin profile should be ordered for a patient with signs of malnutrition, alcoholism, liver disease, gastrointestinal disorders, hematologic disease, neurologic disease, hyperalimentation, pregnancy, and the elderly.

pinocytosis, as well as by simple diffusion, certain well-studied particle-ingesting protozoa serve to assay soluble vitamins and vitamins in particulate, protein-bound form. It has been demonstrated that the practicability of protozoan assays for several vitamin assays, i.e. these micro-animals, often profitably replace large animals for assays and elucidation of the biochemical mechanisms underlying vitamin requirements.

Hitherto, few vitamin assays have proved sufficiently accurate for clinical diagnosis. As biochemistry deepens understanding of intracellular happenings, the need arises for detecting essential metabolites as components of enzymes or interacting enzyme systems. Elucidation of complex nutritional interaction of vitamin systems almost is prohibitively expensive with laboratory animals or tracer methods. If the vitaminic enzyme mediates electron transfer, one finds nicotinic acid or riboflavin; carboxylation or decarboxylation, thiamin or biotin; one-carbon transfer, folic acid and B_{12}, two-carbon transfer, pantothenic acid; three-carbon transfer or synthesis of a single carbon, B_{12}; and nitrogen transfer, vitamin B_6. Using their micro-digestive systems, protozoa respond to a great variety of vitamins in most of their molecular forms with a comprehensiveness matching that of the chick or rat assays.[1,2,4] The criticisms that protozoa generally grow more slowly than bacteria, and that radioactive tracers like $^{57}CoB_{12}$ are faster analytical tools, are of minor importance. One keeps foremost in mind the accuracy and economy of the protozoan assays, and their freedom from radioactivity hazards and that vitamin deficiencies are not emergencies demanding instant analytical values.

ADVANTAGES OF PROTOZOAN ASSAYS

Most studies agree that protozoan methods are the most sensitive and specific way to measure clinically significant forms of B_{12} or in B_{12}-containing products.[1-4]

The availability of ^{57}Co-, ^{58}Co-, and ^{60}Co-vitamin B_{12} has

permitted the wide application of tracer techniques for detecting B_{12}. They require more expensive equipment and rigorous standardization, hence are less suited for routine use than protozoologic assays. Furthermore, the radiometric methods have proved to yield discrepancies between results.[1,3,5] Isotope methods for B_{12} give higher values than protozoan assays and therefore obscure the "true B_{12}" values as well as diagnosis.[3] Evidence recently has been presented to explain why routinely used radiodilution methods yield inappropriately high values for cobalamins:[1,3,5] "R proteins" (cobalamin-binding protein in human gastric juice, devoid of intrinsic factor activity, designated as protein R because of its rapid mobility on electrophoresis) are provided in several assay kits and bind a wide variety of biologically inactive cobalamin analogs beside vitamin B_{12} which are present in serum. These inactive analogs circulate in sufficient concentration to interfere substantially with the radiodilution assay for vitamin B_{12} when pure R protein is used as the binder in that assay. As a result, biologically inactive cobalamin analogs present in human plasma can mask vitamin B_{12} deficiency because, for the reason stated, current radioisotope assays are not specific for true vitamin B_{12}. Much data show almost invariable correlation between clinical vitamin B_{12} deficiency and low serum vitamin B_{12} activity as measured with protozoan reagents, e.g. *Euglena gracilis* or *Ochromonas malhamensis*—a reliability unmatched by the radiodilution assays thus far tested.[3,5] Tracer methods also require expensive radioisotopes, counters and larger samples, and risk of raising the radiation background on prolonged use.

Although B_{12} can be assayed with mice, rats, chicks, and radiocobalt, the protozoan method of assay is preferred, aside from its economy, accuracy, and sensitivity—it detects 1 pg B_{12} per ml—and because of its relative freedom from nonspecific growth stimulations in biologic materials. Ordinary antibiotics do not interfere with protozoan assay methods. Autoclaving procedures used in the assay destroy heat-labile drugs; furthermore almost all drugs are diluted out because of the extreme sensitivity of the protozoan responses to vitamins. Neither deoxyribosides nor methionine can satisfy their B_{12} requirement unlike bacterial assays. Serum and blood from normal subjects have a growth-promoting effect on bacteria exceeding that with *Ochromonas*.[4] The reason for such stimulation is the occurrence of pseudoforms of B_{12} that are found in some biologic fluids.[5] That the *O. malhamensis* method is superior for assay of B_{12} in biologic materials was made clear by the agreement of *Ochromonas* and clinical status.[1,2] When *Ochromonas, L. leichmanni,* and *E. coli* assays for B_{12} in blood, serum, and urine were compared, *Ochromonas* was the most accurate.[6] Serum or whole blood can be assayed, which simplifies the procedure.

We have recounted elsewhere many present biochemical applications of microbiological assays.[1,2,7] I shall keep theory brief while showing how protozoological assays serve as a valuable tool for investigating nutritional status, notably vitamin interrelationships and, indispensably, subclinical deficiencies.

In identifying vitamin involvements in metabolic processes, overall vitamin status routinely is assessed from fluids and tissues as indices. Laboratory tests assume good correlation between concentration of nutrient in tissues, blood, or urine and bodily function. Their usefulness, therefore, depends in large measure on documenting such relationships and ascertaining the intervals in which difference in concentration are significant. That is to say, the validity of various tests designed for nutritional investigation requires appreciation of the distinction between techniques which reflect only the supply of nutrients to the body and those which point to functional deficiency. In choosing the method for studying a nutritional problem, it is necessary to define clearly the objectives: whether clinical diagnosis, fundamental research, or nutritional survey. More significance usually attaches to differentials permitted by a specific assay than to absolute values (these may differ according to the method). It is essential to establish the normal range of values of the method, so that laboratory-to-laboratory variations in absolute values do not vitiate the conclusions, e.g. ability to identify vitamin imbalances and deficiencies. Protozoan assay techniques for nutritional surveys impart a badly needed realism to surveys.[1,2,8-11] Poor methodologies have detracted from previous surveys. Some methods were neither sensitive nor specific enough making indirect methods necessary. In many instances the fluid analyzed—urine—did not yield data correlating well with vitamin status, owing to large variations in these 24-hour samples.

"Many diseases have roots in faulty nutrition, but once the extreme variability of human needs is recognized, medical scientists may better understand a host of diseases of presently unknown etiology."

Many investigators report results as the ratio of a particular metabolite in the urine to urinary creatinine. However, large diurnal and day-to-day variations in urinary creatinine excretion have been charted, suggesting that creatinine values should be used with reserve. Data so tabulated permitted only rough estimates of nutritional status. However, with the advent of the aforementioned protozoan techniques, blood and plasma values now were reliable indices of vitamin status. Earlier no gross circulating diurnal variations in blood vitamin titers were noted, unlike what frequently was seen with urine, except when dietary intakes were such as to cause gross vitamin spillover. Once blood, serum, plasma, or tissue is collected, the specimens can be frozen and shipped for assay; the vitamin titers do not significantly vary in specimens so handled.

VITAMIN DEFICIENCY AND HUMAN DISEASE

The easier quantitation permitted by protozoan techniques should clarify the significance of vitamins not merely in classic nutritional deficiencies, but for metabolic disturbances generally. Overt vitamin deficiencies are inducible by malabsorption, inhibitors of vitamin function, and, sometimes strikingly, by drugs and other toxic substances. Vitamin deficiencies may emerge whenever a metabolism is so altered as to require enhanced quantities of a vitamin to cure or to counteract certain symptoms; B_6- and biotin-dependent infants are good examples.[12,13]

As with other constituents of blood or serum, deviation of vitamin titers from "normal" can mean different things: lowered intake or absorption, increased utilization, increased demand, or increased excretion. Nutritional deficiency states

lacking overt signs can be recognized.[1,2,7,8,13] Subclinical malnutrition—as the phrase implies—is not obvious, but real; it foretells imminent biochemical and clinical lesions. It remains to be determined how malnutrition due to subclinical deficiencies contributes to ill health and senescence.

A vitamin often is the etiologic focus of a disease, e.g. vitamin B_{12} and folic acid in macrocytic anemias. Because of the obvious importance for diagnosis and therapy, determination of the "nucleogenic" vitamins B_{12} and folic acid is a necessity in routine hematology. Where connections between vitamins and a disease are less clear, a wide field remains for detecting correlations between ill health and vitamin and enzyme content of body fluids and tissues. The literature on vitamins in clinical practice depicts a panorama with especially attractive investigating opportunities in hepatic conditions, renal dialysis technique, oxalosis and calculus disease, obscure but widely spread neurologic diseases, and many dermatologic disorders.

The potential importance of the wide variation in individual human nutritional needs has been suggested from our studies and those of others. Granted that diseases are recognized as rooted in faulty nutrition, once the variability of human needs is appreciated, medical scientists will understand better a host of diseases of presently unknown etiology. Hence, once an adequate analytic facility for vitaminology is set up, it can become valuable for diagnosing metabolic imbalances.

A vitamin profile is useful for patients with malnutrition, alcoholism, liver disease, pre- and posthyperalimentation, gastrointestinal disorders, some hematologic diseases, suspected nutritional neuropathies, and hematologic complications of pregnancy.[3,5] A guide to the clinical need for vitamin analyses is given in the Table.

CONCLUSIONS

The eased quantitative determinations of vitamins in body fluids and tissues permitted by protozoal techniques should elucidate the significance of vitamins not merely in classical nutritional deficiencies but in the wider field of metabolic disturbances generally. Aside from the clinical applications of microbiological assays here encountered, largely circumscribed by present biochemical knowledge, there are hints of new applications, many only dimly seen but nevertheless so attractive as to reinforce the practice, verging on routine, of attaching such microbiological facilities to a clinical as well as a biochemical research facility or academic department.

The potential importance of an apparently wide variation in individual human nutritional needs is becoming a pressing concern not only in our own studies but also others. Because the concept of extreme human variability seems to mitigate against the orderliness of science, this subject almost has been shunned. Many diseases have roots in faulty nutrition but once the extreme variability of human needs is recognized, medical scientists may understand better a host of diseases of presently unknown etiology. In any case, once the analytical resource described here is used, it can become valuable for diagnosing a variety of metabolic imbalances involving thiamin, biotin, vitamin B_{12}, folate, pantothenate, niacin, riboflavin, vitamin B_6, vitamins A, C, E, carotene, as well as free and bound choline[14] and, the newly emergent biopterin as an occasional deficiency in phenylketonuria and dementias involving catecholamines.[15,16]

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The Impaired Physician and the Family

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Of the diseases that make up the category we define as "impairment," the illness of the physician has a broad effect on those who surround the impaired healer. When a physician is the victim of one of these diseases, the peripheral effects spread rather broadly. His illness and its effect in making him less efficient in his actions and less lucid in his intellectual functions has a major impact on the quality of care he provides to his patients. While most physicians who are "impaired" are able to function fairly competently until the later stages of their illness, in the beginning there is some loss of skill and judgment. This means that the broad "family of patients" is denied the full expertise which is expected and to which they are entitled. However, within the immediate family the greatest turmoil ensues.

The spouse and children of the impaired physician usually are first to suffer from the side effects while at the same time they are the first to identify the impairment. While all of the "impairments" cause family anguish and disruption, the damaging effects of substance abuse seem to be more severe.

When we speak of substance abuse as a "familial disease," there are two separate aspects of this issue that need to be recognized. First, there is an ever-increasing body of evidence which suggests substance abuse, especially alcoholism, may be an inherited biochemical disorder passed down from generation to generation within the family structure. Dave Smith, of the Haight-Ashbury Free Clinic in San Francisco, likes to discuss the "addictive personality" as an inherited defect and closely relates degree of risk to the incidence of substance abuse in one or both parents. The Swedish Adoption studies that compared children of alcoholic and nonalcoholic parents raised in foster homes by alcoholic or nonalcoholic foster parents strongly suggest that the alcoholic pattern of the biologic parents is the most significant factor in the subsequent appearance of alcoholism as these children reach adulthood.

This special risk has led most of the workers in the field to believe that children of alcoholic parents should be made aware of their background and of the apparent risk that confronts them. They should be encouraged to make very prudent decisions regarding the role that alcohol and other mood-altering drugs will play in their lives. Ideally, total avoidance of these chemicals would be the best decision.

The second aspect of this issue deals with the fact that the entire family is affected when one member suffers from this disease, especially when the member is a parent.

Some typical family problems are:

1. Guilt. The family members may begin to believe the accusations of the victim and feel that somehow they have failed and are to blame for the drinking or drug use.

2. Shame. Embarrassment over the behavior of the substance abusing spouse or parent can lead to the avoidance of social contacts, and an unwillingness to invite peers into the house.

3. Resentment. The demands and behavior of the substance abuser may lead other family members to feel that they would be better off without the substance abuser. Children may resent the "well" parent for not doing something about the problem.

4. Insecurity. As the substance abuser becomes more involved with the illness, the emotional needs of the family are denied.

5. Delinquency. Children trapped in these homes may react by doing poorly in school and by various forms of aggressive or antisocial behavior.

6. Financial Problems. Poor professional performance, declining patient rolls, lost jobs, and poor fiscal responsibility usually lead to serious financial difficulties.

7. Physical Abuse. To the spouse or the child, physical abuse may lead to life-long emotional scars.

Just as denial is a major obstacle in the patient, so too denial often is seen in the family members. This may be due to shame, embarrassment, or honest concern about the perceived threat to the family economic security, if the truth be known.

There are several positive steps the family may take in this situation:

*Dr. Canavan is Medical Director, Impaired Physicians Program. Correspondence may be addressed to Dr. Canavan, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

1. Begin by being honest with yourselves. Face the facts of the illness in your family as they are!

2. Learn as much as you can about the specific illness in your home. There is an abundance of literature available.

3. Build a healthy home atmosphere! Encourage normal social contacts and social outlets for all the family members.

4. Recognize and deal with your own emotions! Depression, anger, and self-pity are common reactions; dealing with them properly will make you healthier and happier.

"The broad family of patients is denied the full expertise which is expected and to which they are entitled."

5. Get all the help you can! AA/NA/AL-ANON/ ALATEEN, the Impaired Physicians Program, your own physician, mental health counsellor, or spiritual advisor can offer assistance in coping with the disease in your household.

6. Be patient and compassionate! These are long-term illnesses and recovery can be a slow process. I have never met an alcoholic or drug abuser who wanted to be one.

7. Be prepared to act! Do not make empty threats. Drastic actions may be necessary to bring these patients into a confrontation with the reality of their illness. Always bear in mind that "blowing the whistle" in these cases can be an act of love!

While these positive steps are important, there are several negative steps that should be borne in mind.

1. Do not allow the victim of impairment to lie to you. The truth often is very painful but it must be faced.

2. Do not take over the patient's responsibilities as th may rob the patient of dignity and increase a negative se image.

3. Do not lecture or blame!

4. Do not cover up or shield the patient from t consequences of his actions. This only prolongs the illne

5. Never "join" them, because you can't beat them! Th will only reinforce the problem and you might end up the same boat.

6. Do not demand or accept unrealistic promises.

7. Never put off facing the reality that these a progressive illnesses which get increasingly worse as th substance abuse continues.

In our program we feel that family therapy and fami involvement are essential ingredients to success. Often, it the family that initiates our therapeutic intervention. would be fool-hardy to attempt to rehabilitate our "falle comrades" without attempting to address the problems the family as well.

Family therapy can begin before, during, or after th confrontation with the impaired professional. Its contir uance should be based solely on the needs of the family an independent of the success or failure of the impaire physician.

Many excellent resources are available to us and ou program stands ready at all times to unite those in need o such services with the appropriate source.

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Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physician Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately, the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

Senior Citizens Independent Community Care Act

SENATOR BILL BRADLEY, Washington, D.C.*

A woman in New Jersey recently wrote a short letter about her struggle to provide loving care for her "mentally alert but extremely feeble" 91-year-old mother who was unable to pay for the constant aid she required. "To have someone come in once a week and give me a whole day to myself would give me a new lease on life," she explained. "We thought about a nursing home, but we just couldn't do it after we examined a few. Even Mother says she has lived too long, but there has to be a better answer besides nursing homes."

Sad as it may seem, we all know that the problem she described increasingly has become common in this country. We hear people talk in almost desperate words about their responsibility for an elderly relative suffering from physical or psychological disability. As another writer stated, "We want to be able to stay at home and help our loved ones there, but with soaring costs and ever tighter restrictions, we're reaching the point of having to hope for an early and painless death at the first sign of a debilitating illness."

Equally alarming is the plight of those elderly people who have no family to take care of them or whose families simply cannot help because of financial, social, or psychological strains. What happens to them? They find themselves trapped inside hospitals and nursing homes—isolated in a lonely, sterile environment and deprived of personal independence and dignity.

There are no easy solutions. I believe that, in many cases, life would be a lot better for elderly people and concerned families if this country developed a program to provide long-term medical and social services at home. Families could be kept intact. The elderly no longer would be forced into institutions, as they are now because Medicare and Medicaid do not pay for needed treatment unless provided in an institution.

In short, if we had a good long-term home care program, we could end a senseless waste of lives and dollars while helping the elderly to be as independent as possible and close to their loved ones instead of being shut away in a hospital or nursing home.

That is why I recently introduced, "Senior Citizens Independent Community Care Act." My legislaton would expand the scope of benefits in the Medicare program to include homemaker-home health aid, adult day care services, interim care, individual assessment, treatment plans, and any other services that the United States Health and Human Resources Department deems necessary.

This measure is cosponsored by Senator Bob Packwood (R-Oregon), chairman of the Senate Commerce Committee. I believe the measure merits swift action in the Congress.

Direct family care is less available than it used to be due to increased life expectancy and the "shrinking" of families because of late marriages, fewer children, more working women, and more divorces.

Long-term care also frequently is unavailable because it is so costly. In general, private insurance either totally excludes coverage for nursing home care and home care, or limits home care to full-time private duty nursing. Therefore, out-of-pocket payments by the elderly equalled almost half the $24 billion spent on long-term care in 1982.

Medicare has focused almost exclusively on institution acute short-term care, specifically precluding any form of "custodial" care. The only instance where Medicare has provided some sensitivity to the growing needs of the chronically ill and disabled is in the area of skilled nursing services. A provision in the 1982 tax bill eliminated the prior hospitalization requirement for skilled nursing services. But there still are limitations on eligibility, and the limit on home health aid has been cut from 20 hours to 9 hours a week.

Medicaid remains the primary source of long-term care funding, but it helps only the very poor. In 1980, only 13 percent of 25.7 million elderly people in this country were covered and less than 6 percent of those in New Jersey were covered. In addition, Medicaid imposes a heavy financial burden on states.

It is clear that we cannot finance a new Medicare program as a cost-reimbursed service. Perverse incentives in our

*Senator Bradley is on the Finance Committee, Energy and Natural Resources Committee, and the Special Committee on Aging.

health care system simply encourage providers to increase services, rather than look for alternatives and efficiencies.

The expanded Medicare program which I am proposing would be open to individuals who are 65 or older and entitled to benefits under Part A and enrolled under Part B. They also would have to have a defined level of physical or mental disability that requires help for a period of at least six months.

"We hear people talk in almost desperate words about their responsibility for an elderly relative suffering from physical or psychological disability."

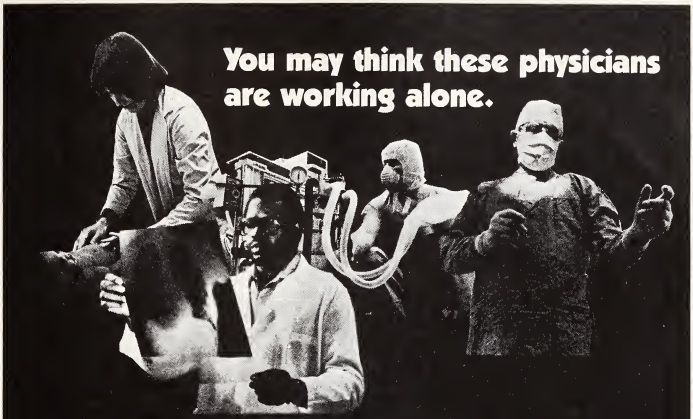
Preadmission assessment teams would evaluate individual health status, functional capabilities, and home or family environment in order to determine the type and frequency of services needed. Such evaluations would be conducted periodically to coordinate the best and most appropriate utilization of services.

Payment of benefits would be based on a capitation method. The fixed per capita fee paid to each provider would be determined jointly by federal and state government officials. In addition, there would be a system of copayments by eligible individuals which would parallel the fees under Part A or Part B for the same services. Those people receiving homemaker-home health aid services, adult day care services, and respite care services would pay a sliding fee indexed to their income.

The services would be supplied by a provider much like a health maintenance organization (HMO). To hold down costs and maximize efficiency, each provider would get only one payment a year from Medicare for each individual participating in the program.

If Congress enacts the legislation, implementation on a national basis would begin after trial runs in about four states to determine appropriate payments to providers and utilization of services.

Overall, this bill promotes what I consider to be the essential features of a long-term care policy: It provides home health care to allow individuals to stay within their families or communities. It uses a capitation payment method to provide incentives for alternative and innovative methods of health care delivery. And, specifically, it targets the high-risk elderly who need home services to avert nursing homes and function independently.



But they really have a team behind them.

These physicians spend most of their day working independently in a one-to-one doctor/patient relationship. And chances are that as a physician, you do too.

But even though you can't see it, there's a strong team supporting and protecting the medical profession, affecting your practice while you see patients, research new drugs or perform surgery. That team consists of *your medical societies.*

The American Medical Association and your state and county medical societies believe in the value of teamwork; that only by working together can we, in the face of an increasingly complex professional environment, protect your right to make responsible decisions on how to practice medicine.

We also believe that all medical societies — county, state, and national — have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

Tasks such as keeping government regulations from interfering with your practice by representing your interests at local and national levels. And challenging regulatory measures that threaten you and your patients' interests by mounting legal campaigns to defend your rights — up to the Supreme Court if necessary.

Why do we believe that *teamwork* means so much to *all* physicians — even those who work "alone"?

Because ... IT WORKS.

Join Your Medical Societies Today.

For more information, contact your state or county medical societies, or call the AMA collect at 312/751-6196. Or return the coupon below to your state or county medical society.

☐ Please send me information on AMA, county, and state society membership.

☐ I am a member of my county and state societies; please send me information on joining the AMA.

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Trustees' Minutes June 12, 1983

A regular meeting of the Board of Trustees was held on Sunday, June 12, 1983, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . .

(1) Contributions for Political Activities . . . Discussed the question of voluntary contributions to JEMPAC; a detailed report will be presented at the next meeting.

(2) DRGs . . . Noted that Doctor Kovacs will be invited by Assemblyman Hardwick to represent MSNJ on a commission to investigate the effects of DRGS.

(3) Attorneys Medical Malpractice Advertisement . . . Authorized Mr. Maressa to take appropriate action to determine if "malpractice advertising" as seen in the *Newark Star Ledger* (June 5, 1983) is permissible in New Jersey.

Report of the Executive Director . . .

(1) MSNJ Financial Statements . . . Reviewed and approved the financial statements for the period ending April 30, 1983.

(2) New Jersey State Medical Underwriters . . . Authorized Mr. Maressa at the annual shareholders' meeting to: vote the shares for the Board; confirm the reappointment of James S. Todd, M..D., to a three-year term on the Board of Directors; ratify the appointment of Dr. Slobodien as Dr. Kovacs's designee on the Board of Directors and Dr. Maurer as the appointee of the New Jersey Association of Osteopathic Physicians and Surgeons; and approve the proposal to retain the accounting firm of Ernst and Whinney as auditors.

(3) Legal Matters . . .

(a) Amicus Representation in Medical Staff Litigation . . . Authorized MSNJ to appear amicus in the antitrust suit lodged against Jersey Shore Medical Center when it denied a podiatrist admission to the medical staff and surgical privileges.

(b) Medicare Reimbursement Schedule . . . Directed that a letter be sent to Dr. Strenger explaining that there appears to be no argument to substantiate his position regarding the change by Medicare to a two-week payment cycle and that a semiweekly payment is an unresponsible time schedule for reimbursement.

(4) Definition of Specialty/Appropriate Designation of Specialty in Medical Fields . . . Authorized Dr. Kovacs to appoint a committee to study and report on the problem of inappropriate physician advertisement and listing of specialty definitions and designations of medical specialty fields.

(5) Blue Shield Service Benefits . . . Noted that an article on the issue of service benefits will be prepared for review for publication in *The Journal.*

(6) End-Stage Renal Disease Services Regulations . . . Noted that the proposed amendments to the standards and criteria for planning and certificate of need of regional end-stage renal disease services has been rewritten to the satisfaction of renal physicians.

(7) Society Publications . . . Noted that all MSNJ publications (except *The Shingle)* will be consolidated into *The Journal.*

(8) The Shingle . . . Sent congratulatory message to the Auxiliary for receiving 1983 AMA Auxiliary Recognition Awards for *The Shingle.*

New Jersey Hospital Association . . .

Mobile Intensive Care Units . . . Noted that hospitals agreed to work with the Commissioner of Health to implement the Part B waiver program.

Note: Waiver holds that MICU will qualify for payment as an outpatient service without meeting the physician and transport requirements.

MSNJ Student Association . . .

Liaison with County Medical Societies . . . Directed that county medical societies be urged to establish a liaison with members of the MSNJ Student Association.

Ad Hoc Committee on Presentation of MSNJ DRG Position . . . Approved a substitute motion that the present members of the Ad Hoc Committee on Presentation of DRG Position be discharged; the Ad Hoc Committee be continued; and the President be authorized to appoint whomever he wishes to serve on the Ad Hoc Committee.

Old Business . . .

(1) Licensing of Podiatric X-Ray Technologists, Orthopedic X-Ray Technologists, and Urologic X-Ray Technologists . . . Declined Dr. Holtzman's request to reconsider MSNJ's position on **S-3080** —MSNJ is actively opposed to this proposed legislation.

(2) Blue Ribbon Committee on the Corporate Restructuring of NJ Hospitals . . . Referred the report to the Council on Medical Services for study and report; a letter will be sent to the Commissioner of Health requesting ample time for meaningful imput from MSNJ on recommendations to guide the formation of Department of Health policy concerning the "unbundling" of hospital services.

New Business . . .

(1) Wellness Incentive for Medicaid Patients . . . Referred the concept of wellness incentive to the Committee on Medicaid for discussion.

Note: Under this wellness incentive proposal, a monetary dividend would be presented upon request to those Medicaid patients that did not require health care expenditures during the course of a year.

(2) Prime Contractor for Medicare Utilization Review . . . Did not adopt the resolution on prime contractor for Medicare Utilization Review presented by the Morris County Medical Society for the following reasons:

a) There are existing physician peer review organizations which already are staffed and equipped to serve as prime contractor. They must resolve the situation themselves.

b) The system being advanced is governmentally sponsored, controlled, and financed. The Medical Society of New Jersey must maintain an objective advocacy for the practice of quality medicine and the patients to be served. These latter goals are paramount and must take precedence over any desire to administer a review system that has the potential for emphasizing interests other than the best medical care.

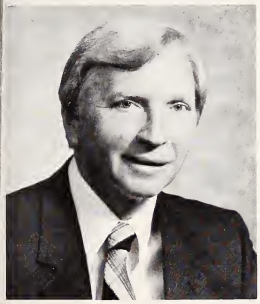
c) The AMA House of Delegates and the Medical Society of New Jersey House of Delegates have spoken strongly against governmentally controlled review systems. MSNJ knowingly should not place itself in a situation which gives the appearance of impropriety.

3) **Number of Practicing Physicians in New Jersey** . . . Will send a communication to the Commissioner of Health calling his attention to the statistics available through the Department of Higher Education stating there are between 10,500 and 12,500 practicing physicians in New Jersey.

President's Column

Alexander D. Kovacs, M.D.

This year, all 120 members of the New Jersey State Legislature are running for reelection. There never has been a more appropriate moment for aggressive political action on the part of our members.



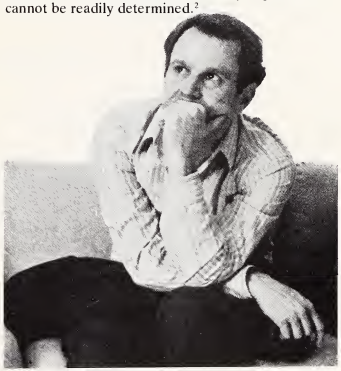
For instance, do you know how your assemblymen and senators have voted on bills of importance to our profession? Have they been willing to meet with you and discuss your feelings about the issues? Also, have you called them in the past two years?

If your political activity has been sluggish in the past, it is time to make a move. I strongly suggest that a group of you who live in a particular district get together and take a politician out to lunch or dinner. If he has not been a good friend or if his political philosophy turns you off, entertain the opponent.

During the past two years, we have seen severe assaults on our profession. In some cases, we have had help from our legislators in staving off those as-

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5,000,000 hospital patients with infections.[1] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[2]



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1. Dixon RE: *Ann Intern Med* 89(Part 2):749-753, Nov 1978. 2. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME; Philadelphia, Lea & Febiger, 1980, p. 1114.

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INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.
CONTRAINDICATIONS: Hypersensitivity to any component.
WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.
PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.
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saults by limited licensed practitioners. We now are facing stiff competition from hospitals who are venturing into the private practice of medicine. You must read the report of the Blue Ribbon Committee on the Corporate Restructuring of Hospitals.

I am sure most physicians welcome competition from our peers. All we want is to be sure that when we all start playing in the same ballpark, we are playing by the same set of rules.

That brings me to the most crucial subject of all—money. Politicians understand money. Lawyers, podiatrists, chiropractors, dentists, pharmacists, optometrists, and hospitals understand money. Physicians do not understand the power of the dollar. We always have proceeded on the basis that since we are in the right, our cause will triumph. Well, it does not work that way.

When you make your choice of a politician to represent you, show your faith with a good contribution.

And do not forget JEMPAC. If you want information about a certain candidate, call JEMPAC at (609) 896-1766 and get the story. Many were turned off by JEMPAC a few years back. The wisdom at that time demanded that money be supplied in equal amounts to both candidates. Now, under the vigorous chairmanship of William Ryan, M.D., JEMPAC evaluates and supports the candidate whose philosophy reflects our own. JEMPAC lacks impact because it lacks funds. Every other organization spends hundreds of thousands of dollars on political activity —JEMPAC has 23 thousand dollars.

We do a good job and we make a good living. We can afford to support good candidates. Our failure to do so is interpreted as apathy or as miserliness. Neither appellation does us good in the political arena. It is time to deliver the one-two punch: meetings and money. Do it as a medical society; do it by yourself. Do it through JEMPAC. The profession you save will be your own.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

The University of Medicine and Dentistry of New Jersey, in line with its statewide mission of filling gaps in specialized health care, has opened a neurosurgical intensive care unit on its Newark campus.

This "high tech" medical unit in University Hospital is the only one of its kind in the state. It was dedicated formally on June 29 with high expectations that it will make a significant contribution to the sophisticated, life-preserving medical care accessible to New Jersey practitioners and their patients.

The eight-bed unit is outfitted with state of the art" diagnostic and monitoring equipment, including an 80,000 Evoked Potential Monitor, which produces a computerized electronic tracing of the patient's nervous system that not only helps to detect injury but to measure the progress of repair from surgery.

Neurosurgical patients needing intensive care are served by a staff of neurosurgeons, specially trained nurses, and a medical director specializing in intensive care.

Faculty members of UMDNJ-Rutgers Medical School are using modern laboratory facilities at Middlesex General-University Hospital in New Brunswick to study and treat the sleep apnea syndrome. The new laboratory facilities are part of the $65 million construction program that followed the hospital's affiliation with the University.

Symptoms of sleep apnea, predominantly a male disorder, include excessive snoring at night and "nodding off" on the job. The syndrome can lead to hypertension, aggravated heart disease or stroke, and even death.

Patients referred to the "sleep lab" for diagnosis go through three to five hours of observation to monitor and record breathing and oxygenation. An electroencephalogram is taken. After diagnosis, recommendations to the patient's physician for treatment range from losing weight to a tracheostomy.

In September, academically superior seniors from 12 Camden area high schools will begin a 24-week course of study intended to give future physicians a realistic picture of medical school and a doctor's life.

Under the innovative Scholars Program, the 12 selected students will be released from regular classes twice a week to attend 110 hours of medical lectures and laboratory sessions conducted by faculty of UMDNJ-New Jersey School of Osteopathic Medicine and staff of NJSOM's teaching affiliate, Kennedy Memorial Hospitals-University Medical Center. Lori Romm Cohen, NJSOM director of special projects, is in charge of the program.

Nearly all of this year's 262 graduates of UMDNJ medical schools secured residency appointments through the national match program. More than half—56 percent—are going to the institutions that were their first choice. UMDNJ residency programs show a slightly higher percentage of United States graduates—almost 80 percent. Foreign physicians comprise about 17 percent, and about 3 percent are United States citizens who graduated from foreign schools.

Antepartum Administration of Rh Immune Globulin

James P. Thompson, M.D.
Chairman, Subcommittee on Maternal Mortality

Rhesus sensitization during pregnancy and hemolytic disease of the neonate can be eradicated by the application of current knowledge. An awareness of the historical highlights of this disease entity provides a fascinating case study of identification, control, and prevention of a leading cause of perinatal mortality.

HISTORY

Perusal of the medical literature reveals descriptions of kernicterus, hydrops fetalis, and erythroblastosis first appearing in the late 19th and early 20th centuries. It was not until 1941 when Levine described the Rh blood grouping system that meaningful insight into etiology occurred.[1] In the mid-1940s, Allen devised a practical method for exchange transfusion of affected newborns.[2] In 1961, Liley introduced evidence from amniotic fluid study that allowed for an accurate depiction of the fetal status prior to delivery.[3] The introduction of Rh immune globulin in 1968 by Pollack, Gorman, and Freda resulted in a great decrease in the incidence of newly sensitized mothers.[4]

MECHANISM

It long has been appreciated that passively administered antibody can prevent active immunization by its specific antigen. Antibody mediated immune suppression—in this case IgG specific anti D—prevents the formation of antibody in a Rh negative patient when Rh positive red cells from the fetus are encountered. The precise nature of the immune response is not known. It is known, however, that complement fixation and hemolysis do not occur following the administration of Rh immune globulin. Phagocytosis and sequestration of red cells in the spleen and lymph nodes do occur. This gives credence to the theory of immune deviation which holds that the vulnerable cells are directed to the lymphatic system and rendered impotent rather than inhibition occurring through a central mechanism involving other cellular components.

Studies by Bowman from the province of Manitoba show the natural incidence of disease to be 12.9 percent of Rh negative gravidas.[5,6] Similarly, he has shown that the effective use of a postpartum immunization program using Rh immune globulin reduces the natural incidence of 12.9 percent to 1.27 percent. The two unsolved dilemmas existing between this greatly lowered incidence and complete eradication are prophylaxis failures and intrapartum sensitization. Much has been written about the former including the development of "fail-safe" procedures but it remains a fact that there is a 20 percent utilization gap—that is, failure to administer the globulin postabortion, after ectopic pregnancies and amniocenteses, and postpartum. Continued educational efforts and heightened awareness may reduce this number. Of similar magnitude is the number of sensitizations that occur during pregnancy and mitigate against the use of postpartum immune globulin. It is estimated that 1 to 2 percent of Rh negative women become sensitized in this manner.

IMMUNE GLOBULIN

In an effort to reduce this latter figure, Bowman has proposed the use of immune globulin in the antepartum period. He suggests the administration of 300 μg at 28 weeks of gestation. There is a biologic half life of 23 days and a concentration of 20 μg present at the end of 12 weeks. This level will be protective against a fetal-maternal transfusion of up to 15 cc of red cells. The antibody traverses the placenta; enters the fetal circulation; and coats the red cells but does not produce clinically apparent disease. It is mandatory that the postpartum prophylactic dose be given in addition. Use of this approach has decreased the overall incidence of sensitization to 0.1 percent—a further 90 percent decrease.

The anticipation of problems—both practical and theoretical—bears comment. A very small percentage of women become sensitized prior to 28 weeks and thus it is a fact that Rh sensitization never will disappear completely using

this approach. A maternal Coombs titer of 1:1 or 1:2 as well as positive cord blood Coombs titer often will develop, but the postpartum dose must be given, when indicated, despite these findings. Anemia and hyperbilirubinemia have never been described in the newborn in the face of a naturally occurring 1:1 or 1:2 titer in the mother. Concern has been voiced about the phenomenon of enhancement—a feto-maternal hemorrhage of significant quantity on the down slope of immune globulin levels—in which an augmented antibody response could result in iatrogenically worsened fetal disease. The fact is that this effect never has been shown to be of clinical significance with Rh globulin.

Bowman and Frigoletto have shown conclusively that antepartum prophylaxis when combined with the conventional postpartum dose is a decidedly cost-effective measure in an attempt to prevent sensitization.[6]

ANTENATAL Rh PROPHYLAXIS: A PROTOCOL

1. All patients identified at the time of initial prenatal evaluation. Laboratory slips will state type and Rh and antibody screen results routinely.

2. All Rh negative patients should be referred to a high-risk clinic.

3. In a high-risk clinic, as laboratory slips are sorted out and patient charts are identified, the patient's chart will get a sticker (flag) stating "RhoGAM™ candidate" and actual date of 26 weeks of gestation (written by a resident).

4. Index cards (3x5) with patient's name, address, clinic number, date of birth, estimated date of conception, and date of 26th week of gestation, to be returned to blood bank. These cards will be kept separately for patient identification and followup. Blood bank will notify clinic/resident/private doctor of any patient that did not receive RhoGAM™ at 28 weeks. Blood bank will check cards every month.

5. Patients are to be scheduled with blood bank at 28 weeks. Blood bank will accommodate clinic patients on Monday morning prior to their routine visit at 28 weeks. Patients will have antibody screen drawn at this time, and return to clinic for visit.

6. After identifying patient for RhoGAM™, blood bank will send RhoGAM™ to clinic for administration by nurse. Patients will receive a card stating date and time of administration. The dose is 300 ng. A copy of RhoGAM™ administration will go to blood bank and in the patient's chart.

7. Patient education—RhoGAM™ pamphlets from Ortho will be given; verbal reinforcement at clinic/blood bank.

8. Antibody screen (done by conventional albumin, antiglobulin technique) will be reported in titers and scores. The titer of an antibody is obtained by testing several dilutions (usually twofold) of a serum against selected red cells. Titers alone can be misleading. Titration results can be expressed with more discrimination by assigning to each reaction a number based on the strength of agglutination observed with that dilution. These values are added to give a score which gives semiquantitative estimate of the strength of an antibody reactivity of strength of agglutination. A strength of agglutination of 4+ has a score of 12, 3+, 10, 2+, 8 and so on. The difference in scores indicates that the serums differ in their strength of activity. A rising titer is to be acted upon in the routine fashion. A score is a number value starting from the high 20s. A difference of 10 points in two score values is significant and needs to be acted upon in a similar way to a rising titer.

9. An Rh negative patient with a weakly reactive anti-D at the time of delivery should receive RhoGAM™ even if she has received antepartum prophylaxis.

10. A screen for FMH (modified K-B test), type and screen and request for RhoGAM™ must be done postpartum. Physician is called directly by hematology laboratory if more than 1 vial of RhoGAM™ is required.

11. Cord blood for type and Rh, direct Coomb's should be obtained on all Rh negative patients, patients without any prenatal care, and patients with type O blood (cost $24).

CONCLUSION

It is suggested strongly that in New Jersey, we undertake an aggressive program of antepartum administration of Rh immune globulin at 28 weeks of pregnancy.

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Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Robert M. Klein, M.D., 5959 Delafield Ave., Riverdale, NY 10471. New York Medical College 1976. Subspecialty, pediatrics. Board certified, pediatrics; board eligible, immunology/allergy. Single or multispecialty group, partnership, solo, institutional. Available July 1984.

ANESTHESIOLOGY—Vithal D. Kardani, M.D., 408 Elkin Residence, 5501 North 11th St., Philadelphia, PA 19141. Shah Medical School (India) 1973. Board eligible. Group or partnership. Available.

Bharati Mistry, M.D., 74-26 45th Ave., Elmhurst, New York, NY 11373. T.N. Medical (India) 1972. Board eligible. Group, partnership, solo. Available.

Robert Sackheim, M.D., 200 Carmen Ave., 2B, East Meadow, NY 11554. Guadalajara (Mexico) 1979. Group, fee for service, solo. Available October 1983.

CARDIOLOGY—Amarjeet Singh, M.D., 5579 Glen Hill Dr., Bethel Park, PA 15102. Patiala (India) 1971. Also, general internal medicine. Board certified (IM). Group, partnership, solo, hospital-based. Available.

DERMATOLOGY—Fred S. Gurtman, M.D., 3760 West Calhoun Pkwy., Minneapolis, MN 55410. Georgetown University (1974). Board certified. Group, partnership, solo. Available.

FAMILY MEDICINE—William J. Rayner, M.D., 616A Country Club Pkwy., Mt. Laurel, NJ 08054. New York Medical College 1975. Board certified. Group. Available.

David M. Horowitz, M.D., 2201 42nd St., NW, Apt. 103, Washington, DC 20007. NYU 1978. Also, general internal medicine. Board certified. Group or partnership. Available.

Khaja Naseeruddin, M.D., 409 North Broadway, Apt. 4S, Yonkers, NY 10701. Osmania (India) 1971. Board eligible.

Group, partnership, solo. Available.

Rabie Glenoa, M.D., 105 Trenton Rd., Overbrook Hills, PA 19151. Cape Town (South Africa) 1977. Part-time family practice or emergency room. Available.

Jan D. Janeff, M.D., 168 Loomis Court, Princeton, NJ 08540. Sofia (Bulgaria) 1953. Board eligible. Group or partnership. Available September 1983.

ASTROENTEROLOGY—Michael F. Fina, M.D., 633 Hertford Rd., Winston-Salem, NC 27104. New York Medical 1975. Board certified. Solo (primarily), group or partnership, second choice. Available.

Kailash Chand Singhvi, M.D., 240 Willoughby St., Apt. 10-C, Brooklyn, NY 11201. S.N. Medical College (India) 1977. Also, general internal medicine. Board eligible (IM). Group or solo. Available.

NTERNAL MEDICINE—Joseph S. Tan, M.D., 3221 Bloomfield Lane, #505, Auburn Heights, MI 48057. University of Santo Tomas (Philippines) 1975. Also, gastroenterology. Board certified. Partnership, group, solo. Available.

Martin Estok, M.D., 50 Wilson Ave., Newark, NJ 07105. UMDNJ 1980. Board eligible. Group, partnership, solo. Available.

David Bleeker, M.D., 200 Carman Ave., Apt. 1-C, East Meadow, NY 11554. SUNY-Downstate 1980. Board eligible. Group or partnership. Available.

Helen Feit, M.D., 7-J Drummond, Rocky Hill, CT 06067. SUNY-Buffalo 1980. Board eligible. Salaried position—OPD, clinic, house physician. Available.

Maureen M. Kelleher, M.D., 85 Fourth Ave., Apt. 7-C, New York, NY 10003. Harvard 1978. Board eligible. Group. Available.

Arvind Mehta, M.D., 805 North Hanover St., Anaheim, CA 92801. University of Bombay (India) 1975. Subspecialty, nephrology. Solo, partnership, group. Available January 1984.

Amarjeet Singh, M.D., 5579 Glen Hill Dr., Bethel Park, PA 15102. Patiala (India) 1971. Subspecialty, cardiology. Board certified. Group, partnership, solo, hospital-based. Available.

Kailash Chand Singhvi, M.D., 240 Willoughby St., Apt. 10-C, Brooklyn, NY 11201. S.N. Medical College (India) 1977. Subspecialty, gastroenterology. Board eligible. Group or solo. Available.

David M. Horowitz, M.D., 2201 42nd St., NW, Apt. 103, Washington, DC 20007. NYU 1978. Special interest, primary care. Board certified (FM). Group or partnership. Available.

Zakia R. Subhani, M.D., 85 Grant Ave., Colonia, NJ 07067. Liaquat (Pakistan) 1966. Board eligible. Any type practice. Available.

Mircea Cornesco, M.D., 415 E. 64th St., 1J, New York, NY 10021. Inst. of Medicine (Rumania) 1952. Group, partnership, solo. Available.

Carolyn Ann Rosenberg, M.D., 15704 27th Ave., North, Plymouth, MN 55441. Baylor College of Medicine 1978. Board certified.

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Group, associate, clinical setting. Available.

Walter H. Sturm, M.D., 140 Hampton Place, Staten Island, NY 10309. SUNY Downstate 1979. Board eligible. Group or partnership. Available.

Richard Eanni, M.D., 19 Fernandez Ave., New Windsor, NY 12550. Rome (Italy) 1972. Also, nephrology. Board eligible. Solo (assuming practice from retiring physician) or partnership. Available.

Leonard H. Kanterman, M.D., 1405 Given Rd., Manhattan, KS 66502. SUNY-Downstate 1977. Subspecialty, endoscopy. Board certified. Group or partnership. Available July 1984.

NEPHROLOGY—Richard Eanni, M.D., 19 Fernandez Ave., New Windsor, NY 12550. Rome (Italy) 1972. Also, general internal medicine. Board eligible (IM). Solo (assuming practice from retiring physician) or partnership. Available.

OBSTETRICS/GYNECOLOGY—Kyung S. Cha, M.D., 240 Willoughby St., 6G, Brooklyn, NY 11201. Korea University 1973. Board eligible. Group, partnership, solo. Available.

Judd Goodman, M.D., 4919 Laurel Canyon Blvd., Apt. 15, North Hollywood, CA 91607. Baylor 1974. Board eligible. Solo or group, preferably in NY metropolitan area. Available.

Gary B. Steinbach, M.D., 6913 Bonnie Ridge Dr., Baltimore, MD 21209. UMDNJ 1980. Board eligible. Group or partnership. Available June 1984.

OPHTHALMOLOGY—Michael Hostovsky, M.D., 4100 West 36th St., Minneapolis, MN 55416. Hadassah (Israel) 1972. Also, neuro-ophthalmology. Board eligible. Single or multispecialty group. Available.

Tariq Saeed, M.D., 6906 Spourse Ct., Springfield, VA 22153. Liaquat (Pakistan) 1968. Board eligible. Group, partnership, solo. Available.

OTOLARYNGOLOGY—Richard Schiffman, M.D., 2717 East 28th St., Brooklyn, NY 11235. Tufts 1977. Board eligible. Partnership or group. Available.

PATHOLOGY—Siamak Shokri-Tabibzadeh, M.D., Montefiore Hospital and Medical Center, 111 E. 210th St., Bronx, NY 10467. Tehran (Iran) 1977. Academic institution. Available.

Marvin N. Solomon, M.D., 3 Sutliff Ave., Vineland, NJ 08360. Berne (Switzerland) 1937. Special interest in anatomic and forensic. Board certified (PA); board eligible (forensic). Hospital staff, locum tenens. Available.

Pushpa Gupta, M.D., 100-C Thorndale Dr., Dayton, OH 45429. S.N. Medical College (India) 1971. Any type practice. Available.

Farhad Setoodeh, M.D., 41 Wild Duck Road, Wyckoff, NJ 07481. Jandishapur 1971. Board certified. Group or partnership. Available.

PEDIATRICS—Steven Lewis Perrick, M.D., 17 Paerdegat 11 St., Brooklyn, NY 11236. SUNY-Downstate 1980. Board eligible.

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Harvey A. Hirsch, M.D., 137-03 70th Rd., Flushing, NY 11367. Guadalajara (Mexico) 1978. Associate, group, partnership, HMO. Available.

Robert M. Klein, M.D., 5959 Delafield Ave., Riverdale, NY 10471. New York Medical College 1976. Board certified; board eligible, allergy/immunology. Multispecialty group, partnership, institutional. Available July 1984.

Frantz Emmanuel Brea, M.D., 89-17 189th St., Hollis, NY 11423. University of Haiti 1971. Subspecialty, neonatology. Board certified. Group, partnership, institutional, solo. Available.

Kothari Purnima, M.D., 950 49th St., Apt. 8-F, Brooklyn, NY 11219. Grant (India) 1975. Board eligible. Group. Available.

PULMONARY DISEASES—M. Zaslow, M.D., 24 Westgate Rd., Chestnut Hill, MA 02167. Harvard 1977. Also, general internal medicine. Board certified (IM); board eligible (PM). Any type practice. Available.

RADIOLOGY (DIAGNOSTIC)—A. Rama Subramaniam, M.D., 186 Ellery Ave., P.O. Box 6189, Newark, NJ 07106. Stanley Medical College (India) 1964. Special interest, nuclear medicine. Solo, group, partnership, academic, hospital-based practice. Available.

SURGERY, GENERAL—Carlos A. Ferrari, M.D., 741 E. Tuscarawas, Barberton, OH 44203. Univ. National of Cordoba (Argentina) 1972. Board certified. Solo, small group, partnership. Available.

Matthew K.Y. Mo, M.D., 38123 Jamestown Dr., Sterling Heights, MI 48077. China Medical (Taiwan) 1974. Also, vascular surgery. Board eligible. Any type practice. Available.

Kothari Mayur, M.D, 950 49th St., Apt. 8-F, Brooklyn, NY 11219. Addisababa (Africa) 1974. Also, vascular surgery. Board eligible. Group. Available.

Jayesh R. Modi, M.D., 740 N. Bruns La., Springfield, IL 62702. Surat (India) 1974. Also, vascular surgery. Board eligible. Partnership or solo. Available.

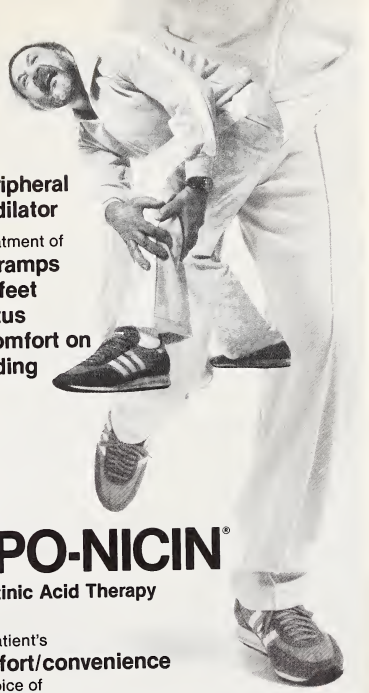
SURGERY, VASCULAR—Matthew K.Y. Mo, M.D., 38123 Jamestown Dr., Sterling Heights, MI 48077. China Medical (Taiwan) 1974. Also, general surgery. Board eligible. Any type practice. Available.

Kothari Mayur, M.D, 950 49th St., Apt. 8-F, Brooklyn, NY 11219. Addisababa (Africa) 1974. Also, general surgery. Board eligible. Group. Available.

Jayesh R. Modi, M.D., 740 N. Bruns La., Springfield, IL 62702. Surat (India) 1974. Also, general surgery. Board eligible. Partnership or solo. Available.

UROLOGY—V.P. Nagarajan, M.D., 61 Maple Ct., Apt. 4, Snyder, NY 14226. Tirunelvel (India) 1973. Solo, group, partnership. Available.

Gary Neal Dunetz, M.D., 310 LaGrange St., Chestnut Hill, MA 02167. SUNY-Upstate 1977. Group, partnership, multispeciality group. Available July 1984.



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NEUROLOGY

Jean-Martin Charcot (1825-1893), the brilliant son of a Paris coach builder, was the founder of modern neurology. In 1862, he was appointed professor of neurology at the Salpetriere Hospital. At the hospital, Charcot created the greatest neurological clinic of his time. He contributed much to our knowledge of the functioning and of the diseases of the brain. Charcot differentiated between neuroses and psychosis and added much to our knowledge of epilepsy, multiple sclerosis, and locomotor ataxia.



Charcot
France, 1960

He was a talented artist, lover of music, and reader of ancient and modern languages. These talents made Charcot the greatest and, certainly, one of the most dramatic and interesting teachers of his time. Students from all over the world flocked to his clinic.

Charcot lived in great style with his heiress wife in a large house on the Boulevard Saint-Germain in Paris.

NEUROSURGERY

Antonio Caetano de Egas Moniz (1874-1955) was born in Avanca, Portugal, and received his medical degree from the University of Coimbra in 1899. After postgraduate study in neurology and neurosurgery, he became professor of neurology at Coimbra and in 1911 was appointed to the new chair of neurology at the University of Lisbon.

Moniz was an original investigator and introduced arterial encephalography. His neuro-surgical research led him to introduce the prefrontal lobotomy of the brain in the treatment of psychic morbid states and similar malfunctions of the brain. Moniz's first memoirs on prefrontal leukotomy appeared in 1936 and for his discovery of the therapeutic value of leukotomy in certain psychoses, he was awarded the Nobel Prize in 1949.



Egas Moniz
Portugal, 1974

Moniz wrote extensively on various aspects of medicine, clinical neurology, pathology, and medical history. He took an active part in public life serving as minister to Madrid, minister of foreign affairs and as president of the Portuguese delegation to the Peace Conference in Paris in 1918.

LETTER TO THE EDITOR

The Medical Director

June 7, 1983

Dear Dr. Krosnick:

According to *The Journal,* the next phase in hospital relations is the interpolation of a medical director between the administration and the medical staff.

Under DRG in New Jersey, the mandate of the medical director will be to keep the boys in line for the governing body and the administration. There is much panic about DRG, and no wonder. It may cost many administrators their jobs. There could be too many of them. For example, DRG seems to require a computerized hospital. The hardware itself for a 300- to 400-bed hospital costs about 1 million dollars, and projected cost for operation annually is about 700 thousand dollars. An administrator, to set the thing up and supervise it, costs about 60 thousand dollars a year. Thus, for 7,000 hospitals in the country, computerization will cost 7 billion dollars to buy and about 5 billion to run annually, which adds up to a lot of patient care.

Now because of this complex tinkertoying with patient health and welfare, it seems we have to add a medical director. This person will cost 100 thousand dollars a year, a sum hard-up hospitals will ill be able to afford, at a cost to a nation complaining about the cost of health care of about 700 million dollars annually of product-less expense.

What do medical staffs really need? A sophisticated administrator who can take over the onerous chores imposed by JCAH. Perhaps a very good secretary could be trained for the job.

Certainly it is wasteful to spend the energies of a well-trained practitioner on such thankless toil. Does he mend a wound, extirpate a tumor, or save a life?

A doctor is only a doctor when treating patients. Medicine has its own intrinsic beauty.

So will our profession be destroyed if our talent is squandered uselessly in nonproductive administrative chores?

The only purpose in creating such an office is to ride hard on the medical staff. A medical degree carries some prestige, and, when subordinate to an administrative officer, lends some wallop to the administrative edict. The medical director, as I perceive him, will be an administrative night stick, consecrated to keeping order in the ranks of the doctors.

The medical director will be required to react to PRO. Since PRO is communicating with the hospital about utilization, the medical director will be expected to monitor utilization; since PRO is communicating with hospitals about quality of patient care (without seeing the patient or the doctor) the medical director will have to referee these confrontations. Since PRO to some extent will govern hospital income can the medical director afford to be neutral? Yet, the medical director, paid by administration, at the urging of JCAH will have to be an accredited member of the medical staff.

The medical director will be the creature of those who pay the salary. It is delusionary to believe that the medical director will be partisan to the medical staff or its members. His job will be to support DRG and PRO, the hospital, and the administration. This obligation is not always consonant with good patient care. Thus, conflict between the medical staff and the medical director is predictable.

It is naive for a medical staff to believe that it can determine the duties of the medical director paid by the hospital. If the medical staff wants its own medical director, it had better pay the salary.

The Journal's treatment of this complex subject was perhaps careless of our interests, something one might expect from the Hospital Association, not from *The Journal* of the Medical Society of New Jersey.

(signed) Charles Harris, M.D.

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NJ

CME CALENDAR

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Sept.

24-25 Advances in Pain Management
8 a.m.-5 p.m.—Resorts International Atlantic City
(UMDNJ and AMNJ)

CARDIOLOGY

Sept.

20 Angina and Step Care
1-2 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

30 Dinner Meeting
7:45-8:45—Ramada Inn, Clark
(NJ State Society of Anesthesiologists and AMNJ)

MEDICINE

Sept.

7 Diabetes: Modalities of Treatment and Management
8 a.m.-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

7 Management of the Diabetic and the Hypertensive Patient
9-10 a.m.—Alexian Brothers Hospital, Elizabeth
(Merck Sharpe & Dohme and AMNJ)

7 The Clinical Use of Diuretics
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

13 Newest Guidelines on Step-Care Therapy in Hypertension
9-10 a.m.—Holy Name Hospital, Teaneck
(Holy Name Hospital and AMNJ)

14 New Concepts of Pain and Pain Control for the Ambulatory Patient
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

14 Abuse of Tranquilizers

21 Current Concepts in the Therapy Common Arthritic Conditions

28 Male Sexual Dysfunction
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

15 A New Approach to the Diagnosis of Thyroid Nodules
8-9 p.m.—Burlington County Memorial Hospital, Mount Holly
(Burlington County Medical Society and AMNJ)

20 Acquired Immunodeficiency Syndrome (AIDS)
12 noon-1 p.m.—St. Mary's Hospital, Orange
(AMNJ)

20 Pulmonary Emboli
9-10 a.m.—Holy Name Hospital, Teaneck
(Holy Name Hospital and AMNJ)

21 Dermatological Conference
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ)

28 Nutrition
9:30 a.m.-4:30 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

29 Irritable Bowel Syndrome and Other Functionally Related Gastrointestinal Diseases
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

Oct.

4 Hymenoptera Sensitivity and Immunological Ramifications
7:30 p.m.—Burdette Tomlin Hospital, Cape May Court House
(AMNJ)

5 Types of Insulin and Modes of Administration

19 Congestive Heart Failure
1-2:30 p.m.—Christ Hospital, Jersey City
(AMNJ)

5 Medical Long-Term Management of Coronary Heart Disease

12 Common Dermatologic Problems in an Office Practice

19 Genetic Disorders of Clinical Significance in the Adult

26 Cancer Epidemiology and Prevention
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

12 Diabetes, Exercise, and the Heart

18 Infections in the Elderly
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

13 Ophthalmology Associated with Systemic Diseases
2-3 p.m.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

18 Herpes Infections
12 noon-1 p.m.—St. Mary's Hospital, Orange
(AMNJ)

19 Acquired Immunodeficiency Syndrome (AIDS)
9-10 a.m.—Warren Hospital, Phillipsburg
(AMNJ)

19 Nonoperative Management of Chronic Back Pain
10-11:30 p.m.—South Bergen Hospital, Hasbrouck Heights
(AMNJ)

19 Pharmacology and Treatment of Chronic Obstructive Pulmonary Disease
1-2 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

19 Hypothyroidism Update
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

NEUROLOGY/PSYCHIATRY

Sept.

1 Morbid Obesity: Update of Causes and Fears

8 Lateral Dominance in Psychiatry

15 Psychodrama as Therapy
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

5 Psychiatric Case Conferences

12 7:30-11:30 a.m.—Trenton Psychiatric

19 Hospital

26 *(Trenton Psychiatric Hospital and AMNJ)*

7 The Unique Role of Creative Arts: Therapies and Therapists
9:30 a.m.-4:45 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

7 Neuropathies of Diabetes
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

7 Guillain-Barré Syndrome
4-5:30 p.m.—Middlesex General Hospital, New Brunswick
(VA Medical Center and AMNJ)

14 Tardive Dyskinesia
10:30 a.m.-12 noon—Essex County

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(Essex County Hospital Center, Sandoz Pharmaceutical, and AMNJ)

2 **The Super-Ego and Psychic Conflict**
8:30-10:30 p.m.—Hackensack Medical Center
(The NJ Psychoanalytic Society and AMNJ)

8 **Medical and Drug Treatment of Multiple Sclerosis**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

Oct.

3 **Psyciatric Case Conference**
10 7:30-11:30 a.m.—Trenton Psychiatric
17 Hospital
24 *(Trenton Psychiatric Hospital and*
31 *AMNJ)*

5 **Approach to the Clinically Suicidal Patient**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

6 **Treatment Refusals in Mental Health**

13 **Depression-Recent Advances in Diagnosis and Treatment**

20 **Culture and Its Effect on Health**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

15 **Prevention of Mental Illness in Children**
9 a.m.-4:30 p.m.—The Mountainside Hospital, Montclair
(The Mountainside Hospital and AMNJ)

18 **Alcoholism**
3-4 p.m.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

26 **Age-Related Clinical Issues**
9:30 a.m.-4:30 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

PATHOLOGY

Sept.

8 **Blood Banking Seminar**
2-5 p.m.—Rutgers Medical School, Piscataway
(NJ Blood Services and AMNJ)

21 **Pathology Slide Seminar/New Procedure Update**
7-9 p.m.—Hyatt House, Cherry Hill
(South Jersey Pathology Society and AMNJ)

22 **Comparative Neoplasia**

29 **Tumor Growth Factors**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

PEDIATRICS

Sept.

15 **Neonatal Resuscitation and Stabilization Workshop**
8 a.m.-4 p.m.—Children's Hospital of NJ, Newark
(United Hospitals Medical Center, NJ Medical School, and AMNJ)

27 **What's New in Pediatric Dermatology?**
8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

Oct.

18 **Advances of Pediatric Cardiology**
8:30-10:30 p.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

RADIOLOGY

Sept.

15 **Lymphoma of the Small and Large Bowel**
7:30 p.m.—St. Barnabas Medical Center, Livingston
(Radiological Society of NJ and AMNJ)

21 **Dinner Meeting**
6:30 p.m.—The Manor, West Orange
(AMNJ)

24- **Basic Echocardiography**
25 9 a.m.-5 p.m.—Nassau Inn, Princeton
(The National Foundation for Non-invasive Diagnostics and AMNJ)

Oct.

6 **The Use of Newer Radiological Techniques in Pediatrics**
9-10 a.m.—Freehold Area Hospital
(AMNJ)

9 **Advanced Echocardiography**

10 9 a.m.-5 p.m.—Nassau Inn, Princeton
(The National Foundation of Non-invasive Diagnostics and AMNJ)

SURGERY

Oct.

6 **Oncology**

13 4-6 p.m.—Institute for Medical

20 Research, Copewood St., Camden

27 *(Institute for Medical Research and AMNJ)*

25 **Impotence-How I Conquered It**
8:30-9:30 p.m.—Englewood Club, 114 E. Palisade Ave., Englewood
(Englewood Surgical Society and AMNJ)

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastics, and Vascular Surgery)

Sept.

14 **Industrial Back Injuries**
7:15 a.m.—Point Pleasant Hospital
(Point Pleasant Hospital)

21 **Microsurgical Treatment of Cerebrovascular Disease**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

MISCELLANEOUS

27 **Basic Computers in Medical Practice**
7:30-9:30 p.m.—Englewood Club, 114 E. Palisade Ave., Englewood
(Englewood Surgical Society and AMNJ)

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 25-hour accredited seminar and workshop on the latest theories & techniques of manual and electro-acupuncture, applicable toward the 200-hour requirement for certification, will be given for licensed clinicians (with or without prior training) during the weekend of August 26-28, 1983 and again the weekend of November 11-13, 1983 at the Barbizon Plaza Hotel, New York City. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its official journal (published by Pergamon Press) the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital, Pharamcology Dept. of The Chicago Medical School. Also eligible for AMA/CME credit. For information, contact Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I), NYC 10032. Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.



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OBITUARIES

Dr. Ralph J. Brennan

At the grand age of 88, Ralph James Brennan, M.D., died on May 5, 1983. Dr. Brennan was a family practitioner in Fair Lawn and received MSNJ's Golden Merit Award for 50 years of service to his community. A graduate of New York Medical College in 1920, Dr. Brennan served an internship at Saint Francis Hospital, Jersey City. Dr. Brennan was affiliated with Jersey City Medical Center, Greater Paterson General Hospital, Valley Hospital, Ridgewood, and Fair Lawn Memorial Hospital. He was a member of our Bergen County component and of the American Medical Association.

Dr. Richard B. Ernest

Richard Bilderback Ernest, M.D., founder and chief surgeon of Trenton Orthopedic Hospital (until its merger with Mercer Medical Center in 1961), died on May 1, 1983. Dr. Ernest was born in 1891 and received a medical degree from the University of Pennsylvania Medical School in 1915. Dr. Ernest was a retired member of our Mercer County component and a member of the American Medical Association. He received MSNJ's Golden Merit Award for 50 years of service to his community.

Dr. Samuel V. Geyer

Samuel Vere Geyer, M.D., a retired member of our Camden County component, died on May 17, 1983. Born in 1917, Dr. Geyer earned a medical degree at Hahnemann Medical College, Philadelphia, in 1942. Dr. Geyer was a Diplomate of the American Board of Radiology and a member of the American Medical Society. Dr. Geyer retired after serving his community for 30 years.

Dr. Max Gross

Max Gross, M.D., the former director of health for Atlantic City and Atlantic County died on May 8, 1983. Born in 1902, Dr. Gross earned a medical degree at Tufts University Medical School, Massachusetts, in 1930. Dr. Gross was a retired member of our Atlantic County component, a member of the American Medical Association, and a Fellow of the American College of Chest Physicians. He was a recipient of the Golden Merit Award for his 50 years of medical service. Dr. Gross was affiliated with the State Department of Health since 1949.

Dr. Robert B. Jeffrey

Robert Brooke Jeffrey, M.D., died on May 3, 1983. Born in 1920, Dr. Jeffrey earned a medical degree at Jefferson Medical College, Philadelphia, in 1945. A member of our Warren County component, Dr. Jeffrey was a Diplomate of the American Board of Radiology and a member of the American Medical Association. During his career, Dr. Jeffrey was affiliated with Warren Hospital, Phillipsburg, as chief of radiology.

Dr. John C. Jones

At the grand age of 96, John Christopher Jones, M.D., died on May 12, 1983. Dr. Jones earned a medical degree at Meharry Medical College, Tennessee, in 1935. Dr. Jones retired in 1976, but during his lengthy career was affiliated with hospitals in Camden County. Dr. Jones was a member of the American Medical Association and a retired member of our Camden County component.

Dr. Emanuel Klosk

At the age of 72, Emanuel Klosk, M.D., died on February 17, 1983. Dr. Klosk was graduated from New York University School of Medicine in 1935. He was affiliated with Newark Beth Israel Medical Center as director of medicine and attending physician. Dr. Klosk was a Diplomate of the American Board of Internal Medicine, a member of our Essex County component and of the American Medical Association, and a Fellow of the American College of Physicians.

Dr. C. Donald Lord

At the age of 75, C. Donald Lord, M.D., died on May 20, 1983. Dr. Lord earned his medical degree at Columbia University College of Physicians and Surgeons, New York, in 1935. Dr. Lord served as the first president of the surgical staff at Valley Hospital, Ridgewood, and also was affiliated with Bergen Pines Hospital, Paramus. He retired in 1976 after 35 years of service to his community. Dr. Lord was a member of the American Medical Association and a retired member of our Bergen County component.

Dr. Franc Puc

Word has been received of the death of Franc Puc, M.D., on January 13, 1983. Dr. Puc was born in 1903, and earned his medical degree at the University of Ljubljana-Zagreb, Yugoslavia, in 1928. Dr. Puc was a retired member of our Hudson County component and a member of the American Medical Association. During his career, Dr. Puc was affiliated with St. Mary's Hospital, Hoboken.

Dr. Herbert E. Reinhold

At the age of 79, Herbert Edward Reinhold died on May 10, 1983. Dr. Reinhold served the town of Englewood for over 50 years and received MSNJ's Golden Merit Award for his service. Dr. Reinhold earned his medical degree at Bellevue Medical Hospital, New York, in 1927. Dr. Reinhold was affiliated with Englewood Hospital as chief of the emergency department. He was a member of our Bergen County component and of the American Medical Association and a Fellow of the American College of Surgeons.

Dr. Richard H. Roberts

Richard Hillman Roberts, M.D., a member of our Camden County component, died on June 1, 1983. Born in 1922 in Camden, Dr. Roberts earned a medical degree at the University of Pennsylvania Medical School, Philadelphia, in 1947. Dr. Roberts was a researcher for Ciba Pharmaceutical Company, Summit. He was a member of the American Medical Association.

Advances In Stroke Therapy

F. Clifford Rose (ed). New York, NY, Raven Press, 1982. Pp. 330. Illustrated. ($58)

Advances in Stroke Therapy is a timely statement of the important aspects of stroke. Writing styles are clear; format is crisp; and illustrations are appropriate. Medical aspects are presented more strongly than surgical therapy.

Even those who have brought carotid artery surgery to a 3 or 4 percent mortality risk compared with a 23 to 45 percent at one to five years, the conservative groups justifiably are humbled by a lay volunteer: "The dividing line between illness (when a doctor can help) and the aftereffect (where there is little a doctor can do)," or "Although it is 150 years since speech therapy began we know little about its effectiveness."

Editor Rose looked at 17 acute stroke trials (1972 to 1981) and concluded "no definitive statement can be made as to the efficacy, or lack of it, of any therapeutic regime that has been tried to date." It follows that this volume is doomed to a finite period of relevance. Those who are looking for a comprehensive yet succinct statement for stroke by the best minds in the field will find it here.

George L. Becker, Jr., M.D.

Cardiac Rhythm Disturbances: A Step-By-Step Approach

William Fox and Emanual Stein. Philadelphia, PA, Lea & Febiger Co., 1983. Pp. 287. ($34.50)

This book is one of many available dealing with the interpretation of electrocardiograms. Its format is unique. There are four sections in the text: 1) supraventricular rhythms and A-V dissociation; 2) heart block and other bradyarrhythmias; 3) ventricular arrhythmias and tachycardias with wide QRS complexes; and 4) parasystole, concealed conduction, intermittent bundle-branch block, other miscellaneous arrhythmias, and artificial pacemakers. Each section consists of a short text where all rhythms in that category are defined. Emphasis is upon definition to the exclusion of causal clinical states or treatments which are kept to a minimum. Paragraphs are concise but sufficient, with little wasted prose. Following the text of definitions is a series of illustrative rhythm strips and 12 lead electrocardiograms which show examples of the previously defined rhythms. Rhythm diagrams are used when appropriate. Legends are succinct. If an electrocardiogram and legend are not sufficiently clear, the reader can return to the paragraph defining the criteria for classification of that rhythm.

This book is not a programmed text for the novice. A basic understanding of electrocardiography needs have been attained beforehand. Morphology of the electrocardiogram is discussed only as it relates to rhythm interpretation. There are no discussions of acute myocardial infarction or ventricular hypertrophy. The text is most valuable as a teaching tool for rhythm interpretation and/or for those versed in but desiring a review of the subject. The illustrations are excellent material to draw upon for teaching conferences. The book is an excellent source of review for someone preparing for cardiovascular boards or in cardiology fellowship training. It can be used as a reference source by the journeyman interpreter when a difficult tracing is encountered. This book is a needed addition to the available ones on the market. The format and ease of reading will make *Cardiac Rhythm Disturbances* a much used volume in the personal medical library.

Robert M. MacMillan, M.D.

Cardiovascular Medicine, Volume 1

John H.K. Vogel, M.D., (ed). New York, NY, Raven Press, 1982. Pp. 390. ($56)

The American College of Cardiology has sponsored this first volume of its extramural program of continued medical education lectures. The editor, Dr. John H.K. Vogel, is professor of medicine and director of cardiology at the Santa Barbara Heart and Lung Institute, California.

This volume is concerned with the most recent advances in cardiovascular disease with particular emphasis on new and upcoming medical surgical treatment, as well as the associated diagnostic techniques and evaluations in the field of cardiovascular disease. Emphasis is placed on noninvasive methods in relation to their utilization and limitations. These papers were presented in Snowmass, Colorado, at the program sponsored by the ACC. There are 62 author-contributed papers listed. Each paper is either illustrated with pictures, figures, or charts and documented with references.

The stage of the text is set with a philosophical essay relative to the application of Rev. Thomas Bayes's fundamentals on numerical probability, judgment, and confidence in the interpretation of laboratory testing results. The issue being: that even with the most esoteric of elective laboratory equipment available for cardiovascular or other types of research, there always remain traces of doubt of the accuracy of interpretation of results by the technician; hoping that with the doubts considered, some certainties will be discovered.

Thereafter, the essays and papers continue with therapies of cardiac arrhythmias, calcium antagonists, and cardiovascular surgery.

This is a fine reference text of practical importance to cardiovascular specialists.

Harry M. Poppick, M.D.

Current Medical Diagnosis and Treatment, 1983

Marcus A. Krupp, M.D., and Milton J. Chatton, M.D., (eds). Los Altos, CA, Lange Medical Publications, 1983. Pp. 1130. ($24)

Here is a book that belongs in the library of every medical practitioner, educator, student, and nurse. It is intended to serve both students and graduates as a useful desk reference on currently available methods for medical diagnosis, treatment, complications, and prognosis. *Current Medical Diagnosis and Treatment* has been revised frequently since 1962, has enjoyed wide acceptance by all health practitioners, and has

appeared in many languages throughout the world.

The format starts with a discussion of general symptoms and fluid and electrolyte disorders, then proceeds to take on each system of the body in a very thorough and detailed review of the most commonly seen diseases or pathology one would expect to see in an office or hospital setting. Rare conditions also are discussed briefly. Each section of review is followed by a short list of current references for more detailed study by those who wish it.

Current Medical Diagnosis and Treatment is well composed and written; easily read as a reference text, especially if one is preparing for CME studies or as a review of differential diagnoses of particular or systemic problems.

I would recommend it as a good value, filled with information and to the point.

Harry M. Poppick, M.D.

General Ophthalmology

Daniel Vaughan, M.D., and Taylor Asbury, M.D. Los Altos, CA, Lange Medical Publications, 1983. Pp. 407. ($17)

Vaughan and Asbury have edited the tenth edition of their classic 1958 textbook. This substantial revision, with the assistance of numerous authorities, has produced a concise and current review of ophthalmology for medical students, beginning ophthalmology residents, practicing ophthalmologists, and nonophthalmic physicians. One of the most remarkable features is the ability of the publisher to keep the cost within the reach of any young student or physician. Its popularity is attested further by five foreign language editions. Considering this, the quality of the printing, binding, editing, and photoreproductions is excellent.

The reader is carried progressively through much of the field of ophthalmology in 26 chapters and four appendices, reinforcing the intimate relationship of the eye to the rest of the body. Extensively revised chapters on optics, preventive ophthalmology, and the ocular manifestations of systemic disease are most commendable.

Dr. Orson White has presented for the first time in ophthalmic literature an enlightening discussion of optical principles used for years by optical engineers. This same author also has given a fascinating exposition of pressure dynamics in glaucoma. Both of these topics alone make the book valuable reading for all ophthalmologists.

Special emphasis is made to guide the student in the proper use of the ophthalmoscope and to understand such observations.

The biggest deficit of the book is the failure to discuss the importance and urgency of treatment of ischemic optic neuritis secondary to temporal arteritis. This topic is touched upon only superficially, even though it is the most urgent ophthalmic emergency.

Routine use of topical gentamicin after corneal trauma is recommended in the chapter, "Principles of Management." Fortunately, the concept of routine topical use of systemic medications is refuted by another contributor; however, the latter discussion is in an appendix which the neophyte may not reach.

Contrary to what is stated, xanthelasma is not an aging change; intraocular lens implants are favored in the majority of cataract extractions; metastatic tumors to the eye are the most common intraocular malignancies. Ultrasonography was omitted for diagnosis of intraocular foreign bodies.

This publication, despite certain objections, deserves an adjunctive position in any physician's library.

Michael L. Mund, M.D.

General Pathology, Principles and Dynamics

D.W. King, M.D., C.M. Fenoglio, M.D., J.H. Lefkowitch, M.D. Philadelphia, PA, Lea & Febiger, 1983. Pp. 550. ($34.50)

General Pathology, Principles and Dynamics is printed on glossy paper. The type is readable and free of errors. The illustrations are clear and the tables are concise. Excellent electron micrographs frequently are used to illustrate cellular anatomy or physiology.

This book is an attempt to integrate the newer developments of microbiology with the classic treatises of pathology. Chapters cover such topics as cellular injury and response, inflammation and repair, agents of disease, general features of neoplasia, aging, and response of the cell.

The book presents agents of disease generally and in relation to specific diseases. Basic principles of immunology and hemostasis are correlated with the inflammatory process.

Multiple factors in the pathogenesis of disease are illustrated by discussions of sickle cell disease, myocardial infarction, celiac disease, viral hepatitis, alcohol toxicity, myasthenia gravis, and diabetes mellitus.

The authors are to be commended for presenting a timely, well-written volume on modern cellular concepts of disease, which is well illustrated. It is recommended to all students of science.

T. K. Rathmell, M.D.

Lymph Node Biopsy

Harry L. Ioachim, M.D. Philadelphia, PA, J.B. Lippincott, 1982. Pp. 438.

This is a well-written, scholarly book comprised of eight parts and a total of 65 chapters. Three parts contain one chapter: Part 1, "The Normal Lymph Node"; Part 2, "The Lymph Node Biopsy"; and Part 5, "Hodgkin's Lymphoma." All the remaining parts range from 10 to 15 chapters. The index which covers nine pages with three columns on each page is very complete and easy to use. Following each chapter (except chapter 2) is a concise "checklist" giving the salient information in that chapter, as well as a list of recent references. *Lymph Node Biopsy* is well illustrated with black and white photomicrographs and electronmicrographs; in the discussions, cytochemical reactions and immunocytologic cell marker studies are included.

Anyone working in this field is aware that there are six classifications of non-Hodgkin's lymphoma. The author proposes not using any of these six, but rather, to use a new tentative one (until all the dust settles) that was published in *Cancer* in May, 1982. This is a "Summary and Description of a Working Formulation for Clinical Usage" and is the result of a National Cancer Institute-Sponsored Study of Classifications of Non-Hodgkin's Lymphomas. It is the work of many of the "super-experts" in this difficult field. Actually, the diagnoses often are not very difficult, but the problem is what term to use.

I believe the first paragraph of the book's preface is worth quoting: "Lymph nodes are among the organs most commonly biopsied for diagnostic purposes. Their easy accessibility makes the morphologic study of lymph nodes a permanent activity of pathologists. Yet there appears to be less agreement between initial and review diagnosis in this field than for other organs." The reasons, I believe, are in part conceptual; in part related to recent rapid advances in knowledge; and in part related to the nomenclature problems.

Ioachim's discussion of the various forms of lymphadenitis is complete and excellent. I strongly recommend this book to all practicing pathologists and oncologists. Any scientist who is involved in research in this field will appreciate this text.

Hugh F. Luddecke, M.D.

Pediatric Hypertension

Julie R. Ingelfinger, M.D. Philadephia, PA, W.B. Saunders Company, 1982. Pp. 320. ($39)

Dealing with a subject that, in the majority of pediatrics textbooks, has been presented in a perfunctory manner, this monograph is highly welcomed and long overdue. It is 24th in the series concerned with major problems in clinical pediatrics.

The subject matter is expounded clearly, concisely, and completely. It ranges from the commonly known etiologies of hypertension in children, e.g. adolescent hypertension and coarctation, to the more esoteric entities, such as Takayasu's arthritis and Ask-Upmarck kidney. The redundancies sometimes found in multiauthored books are not encountered in this single-authored volume.

The biosynthesis of angiotension, aldosterone, renal prostaglandins, catecholamines, and other systems are reviewed and their role in pediatric hypertension is stated, whether proved or controversial. The chapter on hemodynamics and blood pressure is well received, although I doubt if the average physician would remember the physics involved in blood flow mechanisms.

Included in the text are the many modalities at our disposal to treat specific diseases at the varying age categories of hypertension in childhood. The pharmacodynamics of salt restriction, diuretic agents, vasodilators, adrenergic inhibitors, and the like, are presented beautifully. The lag time in developing newer antihypertensives in children is mentioned because, by necessity, drugs have to be mentioned in adult trials initially. The author is discreet in recommending consultations for treatment of the more perplexing problems.

The book's many figures, tables, x-rays, scans, and retinal pictures enhance the subject matter. The references after each chapter are quite extensive.

The appeal for this collected admixture of information would include primary care physicians, neonatologist, cardiologist, and student.

Frank Vanore, M.D.

Rapid Interpretation of Heart Sounds and Murmurs

Emanuel Stein, M.D. Philadelphia, PA, Lea & Febiger, 1983. Tape and booklet. ($18.50)

As advertised, the "Stein way of teaching tapes" is quite listenable and geared to the needs of the aspiring, tyro auscultator. All too often, however, the lucid and simple approach borders on the simplistic. For example, patent ductus arteriosus purports to be the only cause of a continuous murmur; the complex origin of the first heart sound is relegated to A-V valvar closure alone; and "systolic murmurs" include merely those of semilunar stenosis, A-V valvar regurgitation and prolapse, and atrial and ventricular septal defects!

Wide splitting (RBBB) and fixed splitting (ASD) of the second heart sound briefly are alluded to in a confusing and erroneous manner. The effect of respiration on right and left ventricular third sounds is omitted in the workbook, and fourth sounds are depicted as discrete ventricular sounds when, in fact, they are atrial systolic murmurs. The physiologic basis for ejection sounds is not explained, and they certainly are not limited to congenital aortic stenosis (page 41). Differential diagnosis of aortic and pulmonic stenosis and regurgitation is sketchy at best and there is no mention of functional versus organic pulmonic regurgitation. Similarly, the lic "flow" murmurs of atrial septal defect and mitral regurgitation are not described. Finally, differentiation of holosystolic murmurs receives short shrift.

The tape itself is generally good but suffers from the "tin-can" quality of most other recordings. Murmurs often are too harsh, especially, those of mitral and aortic regurgitation as well as that of mitral prolapse. The "unknowns" are well selected although I think that paradoxical and physiological S_2 splitting have been reversed in questions 1 and 5, post-test 1, part B. In post-test 2, part B, question 3, the alleged murmur of aortic regurgitation is too harsh, loud, and difficult to time.

Despite this critique, I would recommend this book-tape to undergraduate students, cardiac nurses, and junior house officers. It will be of little or no value to the accomplished auscultator.

Edwin L. Rothfeld, M.D.

Vaginal Surgery. Second Edition

David H. Nichols, M.D., and Clyde L. Randall, M.D. Baltimore, MD, Williams & Wilkins Company, 1983. Pp. 384. ($39.95)

Much of *Vaginal Surgery* as it appeared in the first edition has been rewritten. From studies of the anatomy of the living, the authors have developed techniques and new objectives emphasizing reconstruction and restoration of normal physiologic interrelationships of the organs and supporting tissues within the pelvis. The relatively new technique of retrorectal levatorplasty has been added to the consideration of posterior colporrhaphy. The diagnosis and operative treatment of the more commonly occurring types of genital fistulae are detailed. An entirely new chapter has been added to expand on the choice of operation for urinary stress incontinence.

Considerable experience has been gained with utilization of the sacrospinous ligament as the optimal tissue for anchoring the apex of the vagina to secure a more desirable vaginal axis. Several plastic procedures are reviewed for the management of congenital absence of the vagina and a vagina that is too small to permit coitus. Elective repair in healthy chronologically old patients has been beneficial anatomically and psychologically. The basic problems to postmenopausal estrogen replacement therapy and genital prolapse are discussed. The final chapter, "Horizons," emphasizes individual tissue variations. It brings into focus many diagnostic and therapeutic questions that remain unanswered.

In general, the text is well organized, well illustrated, and well written. *Vaginal Surgery* is a tribute to the dual authorship. Stanley S. Fieber, M.D.

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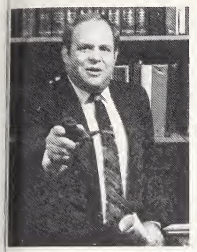
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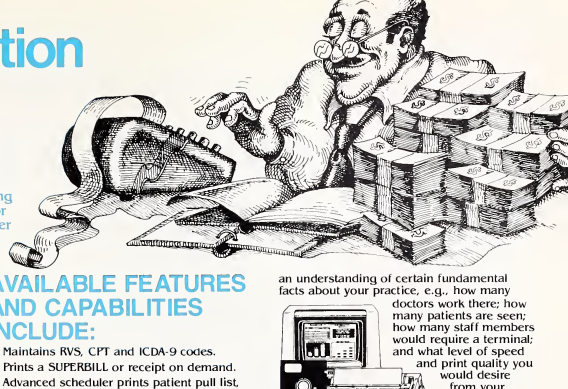
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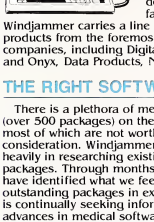
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Journal of the Medical Society of New Jersey

America's First Medical Society

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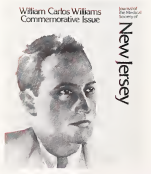
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On The Cover: We celebrate William Carlos Williams, M.D., a man, a physician, and a poet, on the 100th anniversary of his birth. With honor, we present to our readers essays about the man and his work, together with poems and prose, sufficient for each reader to thrive on—and perhaps be motivated to seek more. The specially created cover illustration is by Judi Niemann.

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WILLIAM CARLOS WILLIAMS, M.D.

We celebrate a man, a physician, and a poet, on the 100th anniversary of his birth. We rejoice in his life and his work. The writing he left enriches us all, enlarges the boundaries of our humanity. The medical care which he gave to his community was measured daily in the health of those who lived there. With pride we may point to a man who achieved beyond common measure. With honor we present to our readers essays about the man and his work, together with poems and prose, sufficient for each reader to thrive on—and perhaps be motivated to seek more.

Seek more indeed! Beyond the doctoring and the writing there is a life, of doubt, of hope, of promise, of failure, of stumbling, and of striving—in a word, a life as we all live. Each day requires decisions and compromises by us just to get through the day. Somehow, William Carlos Williams, who cared intensely, who was exquisitely sensitive to himself and to the world around him, who was impatient, and who was impulsive did more. Perhaps that is one standard by which we may measure William Carlos Williams, and in so measuring, measure ourselves.

The pages that follow display material chosen to illustrate several features of the man and his work. There are a number of essays to illuminate the poet, the physician, and the person. Illustrations have been chosen because of their association with Williams or his intimates. The poems and stories are among those that might be meaningful to physicians. We hope the reader will have as much pleasure in this issue as we had preparing it.

The William Carlos Williams Commemorative Issue is cosponsored by *The Journal* of the Medical Society of New Jersey and the New Jersey Committee for the Humanities, Miriam Murphy, executive director. In addition, we received financial support from Johnson and Johnson; Merck & Co., Inc.; and Sandoz, Inc. to help defray the costs of this special issue.

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William Carlos Williams: My Father the Doctor

WILLIAM ERIC WILLIAMS, M.D.*

"How I do long for a full expression of everything that is in me, a free outpouring of everything I feel. I have patience, I have love of men and women and children and trees—I can watch over a thing for years—in fact forever and nurse it into its full strength, but there is still a part of me that yearns for the unknown perfection—not a religious, heavenly perfection but a full-blooded earthly perfection that is fragile as all life is and as sweet."

Writing to his mother in the spring of 1916, my father sounds like anything but a struggling young physician, three years married, father of one, still being judged by the established physicians of the town, school doctor, and serving gratis as physician to the county orphanage. He had established in his own mind in his freshman year at the University of Pennsylvania Medical School that his love lay in the arts, but he would persist with his medical education for the income it would bring, thus making possible the pursuit of his muse. And his practice of medicine, like all things he would undertake, would be a full-time job, conscientiously pursued, the need of his patient always receiving first priority. As if to apologize to the art of medicine for placing it second to poetry in his favor, he would go to the front lines, the trenches where were the truly needy, taking with him his knowledge and skill. He would become what we know now as a family practitioner.

This double commitment, to poetry and to medicine, would dictate his manner of living for the rest of his life. It demanded time and energy, and he would supply both bountifully, often at the expense of his family. Here at home we experienced a daily countdown and "blast off." By the time we assembled for breakfast, he probably had already done an hour's stint on the typewriter. There was no physicians' exchange. The phone was at his elbow at mealtimes, brought to the table on an extension cord. Another interruption was the mailman's whistle, announcing the morning delivery of mail. (A second delivery would come at one o' clock.) The list of calls having been compiled, he was out the door to the garage before we kids had swallowed our cod liver oil and lit out for school. First stop probably was the post office, mailing manuscripts and personal correspondence to maintain communication with his fellow poets, and in later years to advise the young ones aspiring for recognition. Then on to house calls, working his way to the hospital for rounds, clinics, and committee meetings. Finally, he was home for lunch, a sit-down meal, hopefully 20 to 30 minutes allowed for nourishment and conversation with Floss. Then, a quick nap on the couch in the living room, followed by one o'clock office hours, conducted for 40 years without nurse or secretarial assistance. There was a small attached lab for basic blood and urine analyses. House calls again, particularly in winter, with perhaps 15 minutes swiped to get down a fragment of verse on the machine folded away beneath the office desk. Evening came and supper was waiting. Mom frequently telling Lucy, the maid, to put it on the table for herself and us two boys and put a plate in the oven for the doctor. Home to eat. Napkin folded, rolled, and tucked in its ring before the retreat through the kitchen to the office again. Once more office hours from seven to nine, or until the last patient was seen. He hated this ultimate drain on his time and energy, as he would confess years later to Ezra Pound, "I am now engaged in cutting out much of my medical work under the guise of becoming a specialist. Within a few months I will have done with evening office hours, that hellish drag."

Where in this hectic daily routine was there time for poetry? Where would he find energy and peace of mind to give "a free outpouring of everything I feel"? Where would

*Doctor Williams is a pediatrician in Rutherford, a member of our Bergen County component, and the eldest son of William Carlos Williams, M.D.

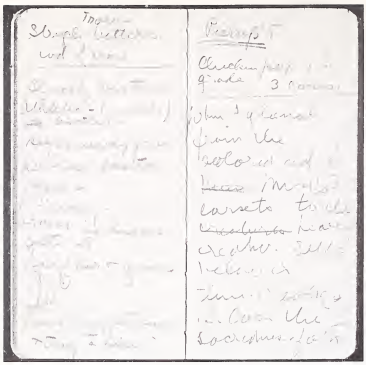


Figure 1—The little red notebook belonging to William Carlos Williams, M.D. Grateful acknowledgment is given to William Eric Williams, M.D., for permission to reprint from this notebook.

he find "the unknown perfection—not a religious, heavenly perfection but a full-blooded earthly perfection that is fragile as all life is and as sweet"? Part of the answer lies in his great opportunism, the talent for grasping, creating, precious moments stolen from that alter ego, the doctor, and used to unburden himself of poetic images. Perhaps on the road to the hospital, the car drawn to the curb and a fragment jotted awkwardly in pencil in a little red notebook (Figure 1) which started life as a record of his doings as school doctor, and became a catch-all for images, phrases, and poems, such as:

> When I glance
> from the
> colored ad of
> Min's
> corsets to the
> healthy
> creature sitting
> below it
> then I realize
> at last the
> sacredness of art
>
> But then
> continuing home
> from the opera
> I enjoy the
> walk under
> the trees in the
> cool more—
> which proves
> art to be
> futile.

But even larger chunks of time were available while the rest of the world slept. It was at night that he would call on apparently endless stores of energy, the tattoo of his typewriter providing a reassuring lullaby to which my brother Paul and I slept and awoke throughout childhood. I can recall the projection of his mood brought to me by the cadence of the keys, the smooth andante when all was happy and serene, and the interrupted staccato when the going got rough, the carriage slamming, and the paper ripped from the roller, balled and heaved in the direction of the wastebasket. Night was his time to roar. Here was happiness, his love, poetry, but apparently in insufficient quantity or quality to completely satisfy. Further along in his letter to his mother he will say: "I must do something . . . some high deed of spiritual happiness, nothing cowardly, nothing low, nothing small—some deed of great love for humanity perhaps, some venture for the sake of poetry, the art I love." And in another paragraph, "I must dare higher. It is only the (?) fire we ourselves put into our lives that gives strength to our imaginations, it is the power of love that makes us live and do. Just as at Penn I gave up dentistry for medicine—just as a little later I really gave up medicine for poetry—and a little later I gave up personal disappointment and its bitterness for dearest Flossie's love and the care of it so now I feel on the brink of a new change."

However, the dream of the artist's life never materialized. It must have been obvious to him that the public was not ready for his work. "Gee Doc, your poetry is very interesting, but what does it mean?" For which he had no answer, maintaining that if the poem had no significance to the reader on first reading, there was little hope that interpretation by the author would give any more profound enlightenment.

One wonders how he originally became involved in the medical process. Being an inexact science, medicine would certainly be no medium for this man of strongly idealistic philosophy to employ in his search for the "unknown perfection," whatever that might be. Undoubtedly, there were parental forces that determined what his role in life would be.

The strongest influence in his home environment was his mother, if only because she was present continually in the home while his traveling papa was elsewhere for the greatest part of the formative years of both Will and his brother Ed. His mother's brother, Carlos, a Paris-educated physician, was apple of Elena's eye, and her total support after the death of her parents. Carlos had returned from France to their home in Puerto Rico, later moving to Santo Domingo, and finally with sister safely married to my grandfather, migrated to the mainland, first to Panama and later to Ecuador. Young Will was impressed by mama, with whom as man and boy he always maintained a very close spiritual relationship, to continue the "tradition" and become a physician.

"Pop" the wandering agent, on the other hand, having very fuzzy familial anlage which his mother, Grandma Wellcome, would never divulge, certainly could bring no pressure based on family precedent. He was, however, a drug salesman on a grand scale. Apparently, his whole professional life was devoted to one concern, a wholesale supplier and importer of medicinals, Lanman and Kemp, 137 Water Street, New York City, was founded in 1808. This required travel to cities as widely separated and disparate as Geneva and Guayaquil, which was no small accomplishment and kept him away from home for months at a time. (There was very little express air travel to Europe and South America between 1880 and 1918 when he died.) What type of agent he was, and how familiar with medical terminology he was, I don't know, but as an indicator of some of the literature he was familiar with, I quote from a letter he wrote to my father on April 27, 1906. "I mailed you yesterday what I think you will find a good book, consisting of extracts from

r. Osler's writings . . . . I read an article lately, from the ondon *Lancet* I think, in which it said that it is a fallacy to ippose that an unlimited amount of menial work can be one if an equal excess of physical exercise is performed."

So we have an English gentleman papa (he never became n American citizen), who is to some extent conversant with iedical literature, apparently for business purposes. Somehow I doubt this was ever a factor in my father's decision to ecome a physician. On the other hand, I feel Mama leaned eavily on her son Will to emulate his Uncle Carlos. She got er wish and thereby initiated a dichotomy in his life which ersisted until in late years a series of cerebral and neoplastic lnesses made it impossible for him to continue either as rtist or physician. During his productive years he had requently flirted with the idea of giving up medicine and eeking his living as a writer. His friend Ezra Pound had rged him to pull up stakes and go to Europe where the ction was, and he and Floss made two trips to France, Austria, and Italy in the 1920s, sampling the Bohemian life of he artists in Paris, and living for a while on the Riviera. On heir first trip, just after World War I, they went to Vienna Vhere Dad studied in the clinics of what were then some of he leading lights in the beginning speciality of pediatrics. It vas on his return to the United States after this experience hat he began to limit his practice more and more to the liseases of children.

I recall a reading one evening at the home of a local physician, the audience consisting entirely of fellow doctors rom his hospital. The gentlemen all were fond of old Doctor Bill. They were polite and attentive, aware of his reputation as a poet, anxious to get the word, i.e. the key to the code hat would make it all clear. His closing lines were much in he form and mood of an orison: "O clemens! O pia! O dolcis! Maria!"

There was an appropriate silence at the conclusion, broken after 10 or 15 seconds by the host who inquired, "Are you a Catholic, Bill?" To which Dad replied in the negative, adding hat so far as formal religion went, he was brought up a Unitarian, though his parents had been Catholic and Church of England. It immediately was apparent to me he was perturbed about something, although it wasn't until later driving home that he could explain his annoyance to me, i.e. he inference that his spontaneous expression of love and respect for some power beyond our understanding must stem rom a formal catechism that dictated his thoughts and emotions (Figure 2). However, there was nothing vindictive n his reaction, for by this stage in his life he had grown to accept his eccentricity and his designation as a revolutionary n the arts.

"Part of the answer lies in his great opportunism, the talent for grasping, creating moments stolen from that alter ego, the doctor, and used to unburden himself of poetic images."

It was a more painful experience to be rebuffed by his brother Ed. The two boys were born within a year of each other. They had always been pals, commuted together to Horace Mann for years, played on the same teams (Dad the pitcher and Ed the catcher), dated the same girls (later each had his proposal of marriage turned down by the same girl), were classmates in Switzerland and Paris, corresponded regularly when Dad was at Penn and Ed at M.I.T., traveled together through Italy in 1910 when Ed was enjoying his reward (studying in Rome) for winning the prestigious Prix de Rome, and Dad was returning to his fiancée in Rutherford after a year of postgraduate study in Leipzig. Our home always featured paintings that Ed gave Dad for Christmas. He was a very good watercolorist, and his works did not suffer by being exhibited on the same walls with Demuth, Sheeler, Hartley, and Shahn. But Ed was a conservative, a student of classical architecture, with no patience for the radical and the outré. His attitude toward his brother's work had always been one of smiling understanding and tolerance—give the boy plenty of rope and he will hang himself sort of thing. But one morning a volume of Dad's poems that he had been at pains to deliver to Ed's home appeared in our mailbox, apparently placed there by Ed on his daily trip by the house en route to the 7:52 A.M. to New York on the Erie. There was an accompanying letter describing the book's contents as vulgar and immoral, incomprehensible balderdash, and something that he, Ed, would not tolerate in his home.

To quote from Chapter 4 of Dad's autobiography, "I'll never forget the dream I had a few days after he [his father]



Figure 2—William Carlos Williams, M.D., and William Eric Williams, M.D., on the roof of the Passaic General Hospital, 1952. Grateful acknowledgment is given to William Eric Williams, M.D., for permission to reprint this photograph.

died, after a wasting illness, on Christmas Day, 1918. I saw him coming down a peculiar flight of exposed steps, steps I have since identified as those before the dais of Pontius Pilate in some well-known painting. But this was in a New York office building, Pop's office. He was bareheaded and had some business letters in his hand on which he was concentrating as he descended. I noticed him and with joy cried out, 'Pop! so, you're not dead!' But he only looked up at me over his right shoulder and commented severely, 'You know all that poetry you're writing. Well, it's no good.' I was left speechless and woke trembling. I have never dreamed of him since."

Misunderstood by the man in the street (whom he dearly loved), an enigma to his peers in the medical profession, condemned as a blasphemer by his closest pal, his brothe and finally as they say in the vernacular "wiped out" by h father, it becomes fairly obvious why he could never cor vince himself that there was a living for him to be made i writing. Fortunately, there was medicine, his entrée into th homes and minds of his neighbors, that qualified him t explore, as he himself put it, the ischiorectal abscesses c mankind, and incidentally thereby earn a living. The "art" c medicine would be his crutch, supporting him and his famil while he was "absent" on his crusade. How successful wa his assault on the citadel only he would be qualified to say Recognition by his contemporaries of a "good try" woul come posthumously as the Pulitzer Prize for *Pictures fro Brueghel.* ■

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For a summary of product information, please turn the page.

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Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid ataxia or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjuctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg daily when 5 mg oral Valium has been determined as the optimal daily dose (no for use in children under 6 months).

INJECTABLE Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer IV slowly*; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or IV, repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (IV preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow IV preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate IV dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Jec® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

ROCHE®

The Horse Show*

WILLIAM CARLOS WILLIAMS, M.D.

Constantly near you, I never in my entire
sixty-four years knew you so well as yesterday
or half so well. We talked. You were never
so lucid, so disengaged from all exigencies
of place and time. We talked of ourselves,
intimately, a thing never heard of between us.
How long have we waited? almost a hundred years.

You said, Unless there is some spark, some
spirit we keep within ourselves, life, a
continuing life's impossible—and it is all
we have. There is no other life, only the one.
The world of the spirits that comes afterward
is the same as our own, just like you sitting
there they come and talk to me, just the same.

They come to bother us. Why? I said. I don't
know. Perhaps to find out what we are doing.
Jealous, do you think? I don't know. I
don't know why they should want to come back.
I was reading about some men who had been
buried under a mountain, I said to her, and
one of them came back after two months,

digging himself out. It was in Switzerland,
you remember? Of course I remember. The
villagers tho't it was a ghost coming down to complain.
They were frightened. They
do come, she said, what you call
my "visions." I talk to them just as I
am talking to you. I see them plainly.

Oh if I could only read! You don't know
what adjustments I have made. All
I can do is to try to live over again
what I knew when your brother and you
were children—but I can't always succeed.
Tell me about the horse show. I have
been waiting all week to hear about it.

Mother darling, I wasn't able to get away.
Oh that's too bad. It was just a show;
they make the horses walk up and down
to judge them by their form. Oh is that
all? I tho't it was something else. Oh
they jump and run too. I wish you had been
there, I was so interested to hear about it.

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ORIGINAL ARTICLE

William Carlos Williams and His Poetry

JOHN CIARDI, Ph.D.*

William Carlos Williams was born September 17, 1883, in Rutherford, and died there March 4, 1963. With some excursions abroad, and to Greenwich Village (which is a foreign country in Rutherford-Paterson), he became a local spirit of his birthplace and of the falls of the Passaic River. His poem, *Paterson,* a vigorous attempt at the eclectic epic, centered on a rock formation roughly in the shape of a man sleeping on his side. The falls of the Passaic boil over this old man of the river, and Williams came to be deeply identified with that eternal sleeping spirit of the place.

Williams's father was English. His mother's family was French-Spanish-Jewish and had settled on various islands of the Caribbean. When the boy was age 14 to 16, his family moved to Europe and he attended schools in Geneva and Paris. Returning home, Williams commuted to Horace Mann High School, New York City, and then entered the University of Pennsylvania Medical School, as one could then do, by examination, without having been an undergraduate. He took his medical degree in 1906, at age 23, and interned in New York City at the French Hospital and the Nursery and Child's Hospital. In 1909, he went to Leipzig for postgraduate work in pediatrics.

Though intimately local, he was hardly the child of Main Street. His schooling abroad and at Horace Mann crossbred his mind with pollen not to be found in Paterson. In Philadelphia, he formed what would be a lifelong though stormy friendship with Ezra Pound. He was stunned by Pound's brilliance, but Williams remained, to the end, a man of orthodox 19th-century moral sensibilities, and as such, remained forever wary of Pound's moral and social pronouncements. In Philadelphia, Williams also formed an enduring friendship with the imagist poet Hilda Doolittle and with the painter Charles Demuth. His friendship with Demuth, and later with other "new" painters, tuned his mind to the emergent principles of modern art, and that art became as strong an influence on his writing as was his acquaintance with the new voices of poetry.

Whatever young man went to Philadelphia, young Doctor Williams returned to Paterson as one of the originating voices of 20th-century poetry. He had a passion to write, and write he did—poems, anecdotes, short stories, novels, memoirs, plays, essays, and an autobiography. In 1958, he published a memoir titled, *I Wanted To Write a Poem.* He might as readily have called it, *I Wanted To Write,* for writing, any sort of writing, certainly meant more to him than the practice of medicine.

I am not qualified to discuss Williams as a physician. In his play, *A Dream of Love,* the main character is a Dr. Daniel Thurber, a physician. He is in his middle 40s, of medium height, dark complexion, and emotional in temperament. Dr. Thurber would like to give up his practice in order to give full time to his writing. Only in writing can he find total self-absorption.

When his wife, Myra, dares him to take down his shingle and to give himself to what really matters, Dr. Thurber's only counter-argument is that they still need the income, little as it is.

Thurber certainly speaks one of the voices of Williams's own inner dialogue. He lived to write anything—except medical papers. And certainly Williams was frustrated in one part of his nature by his medical practice. Yet the daily rounds of his practice were indispensable to him in his role as the spirit of that place. His practice was among the working poor of Paterson and the countryside. His satchel opened doors. He knew his people. One of his poems begins:

> He's dead the old bastard. The dog
> won't have to sleep on his potatoes
> to keep them from freezing.

The poem is not written in contempt. The old man of the river might have spoken those words as part of his census of the people of that place. In time, as Williams walked the streets of Paterson, he recognized, or thought he recognized, every other face as that of a being he had brought into this world. He needed that sense of intimacy with his people.

For Williams, medicine was as much an access as a profession. He was a man of passionate appetite. In an apostrophe to his own senses he wrote:

*Dr. Ciardi is a retired professor of literature, poet, and author of the definitive English translation of the *Inferno* and *Purgatorio* by Dante.

Oh strong ridged and deeply hollowed
nose of mine! what will you not be smelling?
always indiscriminate, always unashamed,
and now it is the souring flowers of the bedraggled
poplars: a festering pulp on the wet earth
beneath them. With what deep thrust
we quicken our desires! . . .
Must you taste everything? Must you know everything?
Must you have a part in everything?

Medicine fed that nose. One of the most memorable of his short stories is "The Use of Force." In it, Dr. Williams comes to a contest of wills with a girl child he suspects of having diphtheria. She refuses, however, to open her mouth to let him have a look at her throat. She resists as if she were fighting off a rape. Her ineffective parents wheedle and beg. Williams scorns them. It is the strength of the girl's spirit that draws him. But she must be protected from her own idiocy. Others must be protected against her. It becomes a contest of wills. Briefly, he finds himself hating the brat. As briefly, he is ashamed of his feelings. Finally, he forces her mouth open —a ravishment—and there are the tonsils covered with membrane. And in his moment of brute triumph, he loves her for the valor of her resistance.

He could even write sympathetically of old Doc Rivers, a cocaine addict and a diagnostic genius who finally may have killed as many patients in his addict's trance as he saved with his medical skill. Everything in life was life and food for his spirit and his art, and medicine gave him an access that was essential to his art.

One may even argue that he oversimplified the principles of his art. He declared that he would have nothing to do with iambic pentameter, with rhyme, with moral assertion. Time and again I have heard him declare from a public platform, "You've got to do away with all that stuff!" In a poem he announced, "No ideas but in things!"

He, of course, was announcing the principles of imagism. Nineteenth-century poetry had become effete and stale, the rhyme foreseeable, the meter tinkly, the thrust of the poem clogged with tacked-on moral assertion. What we call "free verse" had been born, and the label "free verse" was an unsatisfactory translation of French vers libre, liberated verse, verse liberated from these encrustations of weary rhyme, meter, and preachment.

Yet, I must confess that I find little critical substance in Williams. Other poets have managed to adapt iambic pentameter to new and convincing modes, as they have adapted rhyme. Williams invented a theory he labeled, "the variable foot." In 1954, in a letter to Richard Eberhart, Williams explained his "variable foot." He numbered the following lines:

(1) Mother of God! Our Lady!
(2) the heart
(3) is an unruly master
(4) Forgive us our sins
(5) as we
(6) forgive
(7) those who have sinned against.

He then explained:"Count a single beat to each numeral. You may not agree with my ear, but that is the way I count the line. Over the whole poem it gives a pattern to the meter that can be felt as a new measure. It gives resources to the ear which result in a language which we hear spoken about us every day."

It is a vital concern of all poetry to give form and measure to the patterns of living speech. And Williams had an ear. But I cannot find that his critical terms clarify. "A single beat to each numeral?" What I tend to hear is something like a highly formal off-beat iambic pentameter line parsed out around double cesuras. Let me add that when I suggested as much in a piece I wrote in the *Saturday Review* in 1960, I moved Williams to write a wrathful letter. So be it. I have never thought of Williams as a persuasive critic. What he had above and beyond theory was the energy of a vast talent.

Nor has he been pure in the exercise of his talent. Few, if any, of his poems have been more often quoted than the following imagist exercise; the poem is entitled, "The Red Wheelbarrow."

so much depends
upon
a red wheel
barrow
glazed with rain
water
beside the white
chickens.*

But are the first two lines (variable feet?) true to imagist principle? Ezra Pound was ruthless about red-penciling the superfluous. What if those first two lines, in pseudo-Kilmer style, had read, "Even God depends/upon"? Would they then not be brashly visible as a moral assertion? And what then of "no ideas but in things"? In theory, at least, they certainly are fodder for Pound and his red pencil. Pound also was ruthless about striking out superfluous words. Would he have tolerated "water" after "rain"? Or would he have snarled: "You've got to do away with all that stuff." One may argue, of course, that rain water is what stands after rain has fallen. Yet, water and rain, especially when water is made to stand as a separate line, partially are redundant.

For though Williams was one of the revolutionary fathers and founders of 20th-century poetry, he was forever a man of 19th-century sensibilities, and that century's measures, tags, and sensibilities came easily to his mind. A much-quoted late poem by Williams is titled, "Work in Progress," and begins "Of asphodel that greeny flower." Any lyric poet of the 19th-century might have sounded that tone.

In the early poem, "Pastoral" he tells us: "The little sparrows/hop ingenuously." Little sparrows? Are there, by way of contrast, big ones? Ingenuously? How does the word sort with "no ideas but in things"? Pound's red pencil would have been busy here. It should have been busy. And so for the final clip of the poem: "These things/astonish me beyond words."** For what is such a final clip but the very sort of vague, tacked-on moral against which Williams-the-critic inveighed? How different is the saying from such a tawdry vague-off as "these things move me more than I can say"? Or as Williams-the-reader might have said on a sharp day, "Move you hell! When does it move me?"

To cite a later passage from "Work in Progress:" "I was

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cheered/when I came to know/there were flowers also/in hell."* Make what one will of those variable feet (and, as usual, Williams has a fine ear for cadence) but how does he know there are flowers also in hell? Can Dr. Williams guess what they do for chlorophyll? What thing is capturing what idea here? I suspect rather that our revolutionary founder has come in his old age to thoughts of love and death and that his never deeply buried 19th-century sentiments are surfacing through his asserted theory.

Which is only to say that he was a man, a seeker, and confused, and self-confused at times. Had Williams been simple enough—and dull enough—to be narrowly consistent, I could have avoided the maunder and uncertainty of trying to describe him, but then there would have been small reason to describe him, nor would any reader have had reason to be interested in the failure of the description.

His was a passionate energy. That nose was forever sniffing its gross, gallant, tireless, generous, uncritical affirmation. One may draw back from his assertions of critical theory, but never from his talent. What Williams had above and beyond criticism was simply, and massively, poetic gift.

The Desert Music and Other Poems was published in 1954 when Williams was about to have or had just had his 71st birthday. It contains the poem, "The Artist,"** which I will cite as one of the master poems written on this continent, as an example of his perfected gift, and as an instance in which his gift and his theory concurred.

In a more whimsical mood it might have been titled, "Three Variations on the Theme of Whee!" A Mr. T, identified only as untidy, uncurried, and unwashed, is seized by a joyous impulse—whee!—and leaps into the air to perform an entrechat. It is an intricate and skilled figure. Entrechat is, at its Italian root, capriola intrecciata, interwoven wild-goat leap. The English cognate word is "intricate." In an entrechat, the dancer leaps into the air and crosses his legs or taps his heels as many times as possible before coming down. As Nijinsky once commented, it is a good idea in performing an entrechat, to pause at the top of one's leap in order to complete a better sustained figure.

Mr. T
bareheaded
in a soiled undershirt
his hair standing out
on all sides
stood on his toes
heels together
arms gracefully
for the moment
curled above his head.
then he whirled about
bounded
into the air
and with an *entrechat*
perfectly achieved
completed the figure.

The statement and the rhythm come to rest together as sweetly as a ballet figure.

Next to Mr. T, in formal position within the tight context of the poem, sits the poet's mother, in a wheelchair. She responds to Mr. T's impulse. Williams does not stop to tell us that she has that impulse in her soul but is blocked from it by her bad legs. The context and that invalid's chair tell us all—no ideas but in things. And note how different the rhythm of her brief passage is from the Mr. T rhythm:

My mother
taken by surprise
where she sat
in her invalid's chair
was left speechless.
Bravo! she cried at last
and clapped her hands.

The third figure in this formal context is the man's wife. There is nothing wrong with her legs. It is her head, her spirit, that cannot get off the ground. She enters in a rhythm as flat as the scurry of rat's feet:

The man's wife
came from the kitchen:
What goes on here? she said.
But the show was over.

There is no overt commentary. It is the rhythm that characterizes and comments. It tells us beyond the need of words that all joyous impulse is beyond explanation to the inimical flatness of the question.

A poem is, among other things, a formal context for releasing more meaning/perception/feeling than can be overtly stated. When the formal enactment wavers, the poem may wander off into a trek of declarations. And Williams can lapse into mere declaration. But not here. The poem has captured—enacted—a moment from the world and mind and feeling of the poet, and has made this little scene into an experience in which we now—and for as long as we remember—participate.

We have had that experience, moreover, under the spell of a master talent. We feel in ourselves how utterly the show is over. But only in the context-sprung presence of that wife. In the presence of the poem, it is never over.

Perhaps Williams was right. Perhaps there are flowers also in hell. Our sense of fact tells us there cannot be flowers there. But that is merely fact. I can be made to grow respectful toward hard fact when the surgeon is cutting me. Once I have been closed up again and am beginning to feel whole, I know there can be flowers wherever a true poet puts them in our imagination. Where science touches man, it turns to art:

How shall we get said what must be said?
Only the poem.
Only the counted poem, to an exact measure:
to imitate, not to copy nature.

That, of course, is declaration. It is less a poem than a clue to the intended motion of the man's poetry. Call it the sort of thing he said to himself between the moment's of his purest invention. At his peaks, Williams gave a nature to our poetry by creating a place we can live and feel in. He's dead, the gorgeous old bastard, but nothing will freeze his flowers. They are planted inside us. ■

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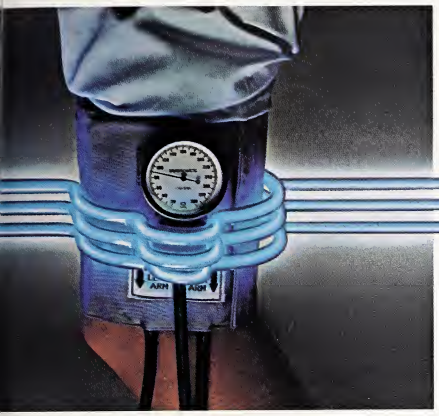
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Please see next page for brief summary of prescribing information.

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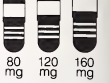
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(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR)
INDERAL® LA BRAND OF propranolol hydrochloride
(Long Acting Capsules)
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.
INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.
INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.
The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of the release by the kidneys, and (3) centrumediated tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effective control of blood pressure by the once-daily dosage of INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.
In angina patients, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end-diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.
In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in therapeutic dosage is not established.
The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.
Beta-adrenergic blockade can modify some symptoms in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should not be blocked in the presence of AV block greater than first degree. Beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.
Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension. It may be administered alone or in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.
Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.
Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.
Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially in the treatment of exertional angina, of congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated or are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.
IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued gradually.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema). PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.
MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.
INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.
DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.
THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.
IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. General. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.
Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.
Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.
DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.
Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproduction studies in animals did not show any impairment of fertility that was attributable to the drug.
Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at dose levels about 10 times greater than the maximum recommended human dose.
There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.
Pediatric Use. Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.
Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.
Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.
Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.
Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.
Respiratory: bronchospasm.
Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.
Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.
Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.
HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.
ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.
If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).
MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.
HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Bicentennial

JOHN CIARDI, Ph.D.

This official bicentennial arts person programming
state-wide culturals for the up and coming
year-long Fourth of July, made an appointment,
and came, and I said I would (what I could),
and she said, "Are there any other New Jersey
poets we should mention?" And I said,
"Well, William Carlos Williams to start." And she
said, "Has he published books?"
  And I saw hall on hall
of stone glass buildings, a million offices
with labels on glass doors. And at the first desk
in every office, nothing. And beyond, in the inner
office, nothing. And a lost wind going, and doors
all swinging bang in the wind and swinging bang.
And at the end of every corridor
a wall of buttons blinking data dead.

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William Carlos Williams: A Remembrance

ENRY NIESE

In the late 1940s and early 1950s, while an art student at Cooper Union, I used to hang out with a group young painters from New Jersey. We were all in the rocess of discovering ourselves, modern poetry, and music. n addition to painting, we also wrote poetry, made huge onte environmental sculptures or designs on the winter eaches of Bay Head that were swept away by the wind and de rather shortly, and we made improvisational music on iakeshift instruments. There were no tape recorders then, ut we recorded these efforts on a disc recorder.

Jackson Pollack, Franz Kline, and Willem de Kooning ad first shows at this time, known as action painting or bstract expressionism. John Cage and Edgar Varese's first ecordings were issued, and *Paterson 3 and 4* by William Carlos Williams were published also during this period. The vork of all these artists excited us immensely. We felt, in spite of their seniority, they were fellow artists, and we wanted to meet them and exchange ideas with them.

In fact, we did meet and become friends with many of hem. We would gather together to try to figure out how to make contact. "Well, Varese lives in New York City. Let's see if he's in the phone book." Varese himself answered the phone, and hearing that we made music, immediately invited us over to his studio on Sullivan Street. He became terribly excited when he heard our records and demanded the scores, saying he could get them published immediately. When he found out there were no scores, he lost interest.

One day someone said, "Williams lives in Rutherford. Let's try the phone book again." There is a line in *Paterson* that uses the word "Kanaka." We thought we'd be smart and do a pun on the old "knock-knock" joke, seeing as how we were metaphorically knocking on his door for the first time. So, when he answered the phone we said, "Kanaka, Kanaka," expecting him to enjoy our wit. "Kanaka, Kanaka yourself, who the hell is this?" said Williams.

Somehow we were so stunned to be speaking to the great man, and so embarrassed by our corny joke, that we hung up without saying a word. It was not until 1955 that I finally met him and became close friends with him for the rest of his life.

That year, 1955, I was in a show at the Silo Gallery in Morris Plains. Cyril and Phyllis Farny, the owners of the gallery, arranged for Williams to give a poetry reading in the gallery one evening while the show was hanging. At the reception after the reading, we were introduced. I was amazed and excited that Williams took such an immediate interest in me, a young and relatively unknown artist. I was 30 and had won a couple of prizes for my painting which had enabled me to buy a small farm in Hackettstown. He wanted to visit my studio, and asked me to stop by and see him in Rutherford while on my way into New York.

A couple of weeks later, following his directions, I found his house at 9 Ridge Road, in Rutherford, and was led into the living room by Flossie Williams and Stormy, the family dog. It was a big, old house, full of light, with beautiful paintings by Marsden Hartley, Charles Demuth, and an original Audubon in the dining room. Bill came down from his studio and we talked about art—particularly Kline, de Kooning, and abstract expressionism. He didn't quite know what to make of it. I think the absence of a recognizable image had him buffaloed for a while.

He walked me out to my station wagon; I was on my way into the city to deliver a new painting to my gallery. When he saw the painting in the car, he made me haul it out so he could look at it. It thoroughly satisfied him; a recognizable image of an American farm interior.

Later, I realized that the reason he liked my paintings so much was that they had something in common with his poetry, which often dealt in a simple and direct way with

*Mr. Niese is a painter and professor at the University of Maryland. His work has been shown in the United States and abroad and his paintings are in collections around the country. A Sun Dancer, Mr. Niese has been trained in and practices American Indian medicine.

images. Both of us were striving for larger general human values through simple particular objects and images.

Stopping by the house in Rutherford to show him my new work on the way into the gallery in New York became a customary thing to do.

Several times Bill and Flossie spent the weekend at my farm in Hackettstown. He was very lively on those occasions, enjoying himself a great deal, sitting by the potbelly stove in my studio, talking about art and love and other things. One time I was on the outs with my wife and I thought, "Well, here is a man with great wisdom and sensibility about these things who has written marvelous love poems and lived a full life." So, in a general sort of way, I asked him about men and women, and how one should deal with the problems that come between them, expecting some useful words of wisdom. His face became a picture of perplexity. He lifted his hands and shrugged his shoulders. He said, "I don't know, Hank. I used to think I knew, but I just don't know!"

One Sunday evening while I was driving him and Floss back to Rutherford, he said to me, "I'm going to write another book to *Paterson*. It's going to be about the artists—book 5. They [the critics] won't know what to make of it."

"He had a humility and a generosity that allowed him to see value in the most ordinary people and things. He was a complicated and sophisticated man."

One day I walked into the house in Rutherford and Flossie directed me upstairs to Bill's studio. Bill practically was jumping up and down with excitement. He handed me a manuscript and started telling me about the young poet, son of a friend of his in Paterson, and how this young poet over the years had sent him manuscript after manuscript of terrible poetry, and how Bill eventually didn't even open them, but threw them in the corner of his studio. He showed me the pile. The last one had come, and he had thrown it with the others. But then Flossie had rebuked him, saying that he owed it to the young man to read the manuscript.

He had dutifully opened the last envelope to come and was electrified by its contents. "Read it," he said, "It's absolutely terrific. I'm going to write an introduction to it!" It was *Howl* by Allen Ginsburg, published later that year by City Lights in San Francisco. The last line of Bill's introduction read, "Hold back the edges of your gowns, ladies, we are going through hell."

About that same time in 1956, Bill wrote a short essay about my work which was printed in the brochure of my first one-man show at the "G" Gallery in New York City. When he sent it to me he wrote a note saying that if I didn't like it I should, "—Bleat like a lamb or a capretto—" and he would do it over. It was a reference to the animals he loved to watch on my farm.

Very early in our friendship I was impressed with his way of looking at things, his ability to pick up details that would pass by the ordinary observer. It is a common assumption that we are born with the ability to see. But seeing, like dancing or singing, is a learned skill. That is the artist's skill, and Bill had the eyes of a painter. It was obvious in his writing, and even more so in the way he related to the environment.

Bill had been very close to the painters of his generation, including Hartley and Demuth. One day he suggested that we take a ride "up the river" to see his old friend, Charles Sheeler, near Irvington, New York. Sheeler was one of the artists I respected greatly, and I was enthusiastic about the idea. The arrangements were made, and a week later I picked up Bill and Flossie on a beautiful summer day. We drove north, Bill giving the directions and constantly pointing out unusual objects and color relationships.

The Sheelers lived in a guest house or gate house on a large estate. Charles Sheeler had a beautiful collection of Shaker furniture, and I immediately recognized the source of a number of his paintings. At the time I was doing a series of paintings of farm interiors and furniture, so it meant a lot to me to be able to understand how Sheeler had transformed this reality I was standing in, to another one on canvas. There is a Sheeler painting of a long table, rug, and chest. I had thought of it as a neo-Cubist abstraction, in spite of the representational elements. Coming down the stairway in the house, looking into the dining room, I saw the table, rug, and chest, and realized that he had painted the picture quite naturalistically, using the high point of view from the stairs to flatten out the perspective in a Cubist way.

Sheeler's drawing table was in the dining room, and on it was a small drawing he was working on. I asked him why he didn't do any more of the beautiful large conte crayon drawings like "Interior with Stove," one of a series of fantastically precise and luminous drawings for which he was famous. He told me that those drawings had each taken about three months to do. The last one had been like purgatory. He had had to hold a large handkerchief to his head for the whole time to prevent the sweat from dripping onto the paper, which would have ruined the drawing. "I didn't get much for them either," he said.

Musya Sheeler made a lovely lunch, and the four old friends spent the afternoon enjoying each others' company. Toward evening, we said goodbye and drove back to New Jersey. I think it was the last time they saw each other (Figure 1).

Williams received many invitations to read his poetry. A group of them came in from several colleges in Pennsylvania, and he decided to make a tour of it, going by train. As the time for the tour grew closer, he began to dread having to travel by train and asked me if I would consider driving him. It would take four or five days, the expenses were on him. I had just finished a big painting, so I said yes.

It started off like a lark. Flossie packed us a picnic lunch, and we took off to the hinterlands of Pennsylvania.

One of our stops was a small state college. When the chairman of the English Department took us to his house, it seemed strange that the only books he had were *Reader's Digest* anthologies. The only records in the house were Broadway musical soundtracks. When the gentleman and his wife left us alone for a moment, Bill whispered, "Do you suppose he owns any books at all?" Later on Bill asked the man which of his, Williams, books were in the college library. The guy said that at present there were none. I had the feeling that Bill was going to have a hard time.

The next day the chairman put Bill through a terribly strenuous schedule. All Bill was supposed to do was to meet informally with the students for lunch and then give his poetry reading in the afternoon. I suppose the chairman was trying to get the most for his money, but he had Bill speak to both his freshman English classes in the morning, then autograph each student's textbook, and meet with the faculty

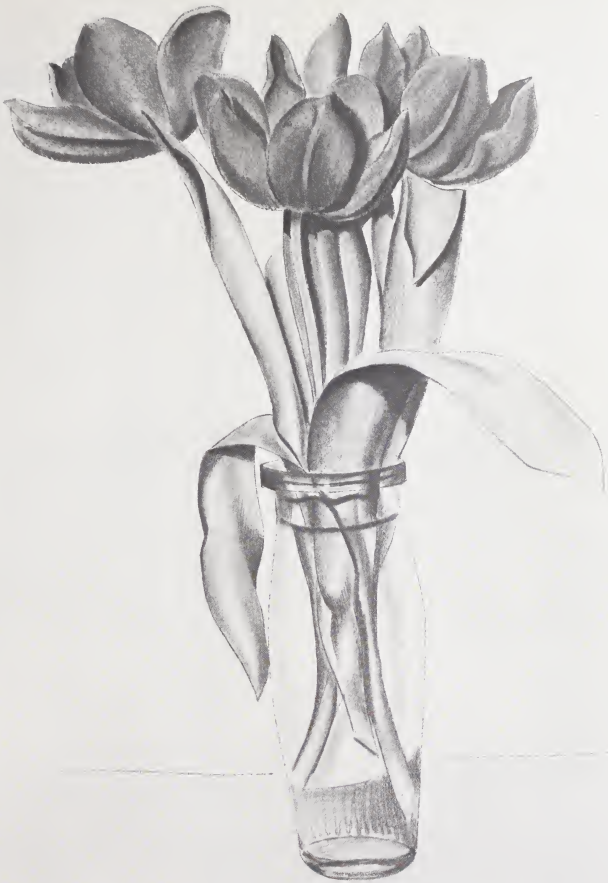


Figure 1—*Leaves, Flowers and Glass.* Charles Sheeler, 1922. Photographed by Joseph Crilley. Grateful acknowledgment is given to The New Jersey State Museum Collection, Trenton, for permission to reprint the painting. Museum purchase.



Figure 2—*William Carlos Williams and Ezra Pound.* At the home of Williams, June 30, 1958. Photographed by Richard Avedon.

before the lunch. Bill was not physically strong at the time, and his handwritting was painfully slow and shaky due to his stroke. Yet his kindly nature would not let him say no to all the extracurricular activity. By the time he got the books signed, met with the faculty, and lunched with the students, he was pretty tired, so he was not at his best for the poetry reading.

After the poetry reading we were getting ready to leave when the chairman announced he had planned a dinner at a restaurant so that Bill could meet the local dignitaries. I got Bill aside and told him he had every right to decline, that it had not been on the agenda. But Bill said that we had better go.

There were about 15 businessmen at the dinner, including the mayor, chief of police, two automobile dealers, and a banker. The conversation was mostly about the local economy. Bill gamely tried to hold up his end of the table talk, but he was plainly uncomfortable. We left as soon as we could politely do so.

In the car Bill groaned and said that he hoped he would not have to go through that again. He needn't have worried.

Harry Garvin's house at Bucknell University, our next stop, was full of books, music, and paintings. The Garvins were marvelous hosts, and at the poetry reading the next day, Williams was in top form. It, perhaps, was the most inspiring performance I ever saw him give. He enjoyed himself thoroughly in the discussion following the reading, and it was plain that the students were enjoying him, too. The high from that meeting lasted all the way back to Rutherford.

That Williams would allow himself to be taken advantage of, which I saw on several occasions, was part of the special nature of his character. He had a humility and a generosity that allowed him to see value in the most ordinary people and things. He was a complicated and sophisticated man, yet he gravitated to the simple, the humble, and the innocent in the life he lived and wrote about. Dining with the banker and the car salesman may not have been his idea of a good time, but they were part of the great American environment, and he paid attention to them and respected them, in the sense that they were fellow human beings.

I had to go into the city one day, so I called Bill to see if it was all right to stop by and see him. "For God's sake, don't come. Ezra just got out of St. Elizabeth's. We sneaked him in here. The press suspects he's here and we're in a state of siege!"

Ezra Pound finally had been released from his confinement in St. Elizabeth's Hospital in Washington, D.C., his punishment for making propaganda broadcasts for the Nazis during the war. He had gone straight to Bill's house to wait until he could sail for Europe. Williams kept his presence secret, but the networks and papers had set up a vigil outside the house for days, making things difficult for all concerned.

Although they had been friends in school, and remained friends, Pound and Williams had gone on widely diverging paths, each celebrating a different world. Bill mistrusted Ezra's elitist cosmopolitanism, and Pound put down Williams for his sticking to the local details. While Pound was staying at 9 Ridge Road, the only photographer admitted to the house was Richard Avedon. A few weeks after Pound had left, Flossie showed me a print of the picture that had been taken of the two men. The photograph (Figure 2) is a beautiful and subtle statement of the two poets' characters. It is a psychological study of their differences, as well as their relationship to one another. Bill looks solid as a rock; Ezra looks pale and ghost-like. It is as though the instant with the camera means everything to Ezra, and very little to Bill; as though Bill would rise momentarily and go off to investigate what has caught his eye; as though nothing Ezra could do would stop Williams.

In 1960, on my way into the gallery in New York, I stopped by Bill's house (Figures 3 and 4) and showed him a big landscape with a row of stumps of a cut-up tree in the foreground. It was painted so that the time of year was ambiguous, either winter or summer. The image excited Bill, and I used a reproduction of it on the announcement for my next show the following month. A couple of days after I sent him the notice for the show, I got a brief note from him attached to a poem he had written about the painting. The next mail brought another note with a second version of the poem. The note read, "Final version. Destroy the preceding one. It's amazing how a man has to work to come up with the cutting of one letter from his composition! Fine day today." The next day brought an envelope marked "Final edition." The poem, "Jersey Lyric," was the version published in *Pictures from Brueghel* (Figure 5):

view of winter trees
before
one tree



Figure 3—*William Carlos Williams and Henry Niese.* At 9 Ridge Road, Rutherford, 1960. Grateful acknowledgment is given to Henry Niese for permission to reprint this photograph.



Figure 4—*Williams Carlos Williams and his wife, Flossie.* At home, 1960. Grateful acknowledgment is given to Henry Niese for permission to reprint this photograph.



Figure 5—*Jersey Lyric.* Henry Niese, 1960. Grateful acknowledgment is given to the collection of Mary Jane Morrison, Boulder, Colorado, for permission to reprint this painting.



Figure 6—*Wall Street, Trinity Church.* John Marin, 1924. Photographed by J. Crilley. Grateful acknowledgment is given to the New Jersey State Museum Collection, Trenton, for permission to reprint the painting. Museum purchase.



Figure 7—*The Sea Off Cape Split, Maine.* John Marin, 1939. Photographed by Joseph Crilley. Grateful acknowledgment is given to The New Jersey State Museum Collection, Trenton, for permission to reprint this painting. Gift of John Jr., Norma, and Lisa Marie Marin in memory of Lyda and Retta Currey.

in the foreground
where
by fresh-fallen
snow
lie 6 woodchunks ready
for the fire*

Until the very end, Williams kept his vision fresh and clear. It was a vision that came from the way he lived his life. He wrote about the tangled life of the city, but he was a suburban man, even a country man. He knew and wrote about calamus, swamp mallow, tansy and comfrey, and the old country medicines. He loved the birds, especially the common ones, the sparrow and the grackle, and he observed them as carefully as he did his patients. They were all the source of his vision, and he found relationships between them all—people, plants, the birds, even the rocks of the earth—in a life-long song about his environment (Figures 6 and 7).

He fought a great battle with the medical problems that beset him in the last years of his life, yet he never became more than momentarily disillusioned and tired. Winter became his enemy, and living through it to spring became his goal. If he did that, he thought he could make it another year. The winter before he died he was miserable. He said to me, "Hank, if only I could die honorably. Suicide is cowardly, but if one of those cars— would run me over—" He didn't finish the thought.

*Grateful acknowledgment is given to New Directions Publishing Corp. for permission to reprint "Jersey Lyric" from *Pictures from Brueghel and Other Poems* (copyright © 1949, 1951, 1952, 1953, 1954, 1962 by William Carlos Williams).

He died in early March 1963, having almost made it into spring. At the end of his poem, "The Sparrow," he describes the death of the sparrow:

Practical to the end,
it is the poem
of his existence
that triumphed
finally;
a wisp of feathers
flattened to the pavement,
wings spread symmetrically
as if in flight;
the head gone,
the black escutcheon
undecipherable,
an effigy of a sparrow,
a dried wafer only,
left to say
and it says it
without offense,
beautifully;
This was I,
a sparrow.
I did my best;
farewell.*

I knew he was thinking of the sparrow when he said those last words to me. ■

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There is a road.

Many cancer patients need transportation to and from treatments. That's why the American Cancer Society has formed groups of volunteers across the United States who give a few hours of their time each month to drive them. The road to recovery can be a long and difficult one, but it can be that much easier when there are friends who can help along the way.



American Cancer Society

This space contributed as a public service.

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BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, or other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients; transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request

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"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

*Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page*

Fine Work with Pitch and Copper*

WILLIAM CARLOS WILLIAMS, M.D.

Now they are resting
in the fleckless light
separately in unison

like the sacks
of sifted stone stacked
regularly by twos

about the flat roof
ready after lunch
to be opened and strewn

The copper in eight
foot strips has been
beaten lengthwise

down the center at right
angles and lies ready
to edge the coping

One still chewing
picks up a copper strip
and runs his eye along it

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ORIGINAL ARTICLE

William Carlos Williams and Charles Demuth

ARTHUR KROSNICK, M.D.*

Whatever else he may have been, William Carlos Williams was a humanist as well as a humanitarian. None can question that he was a student of literature, a man of letters, a scholar, and a thinker. His literary works speak for themselves. Dr. Williams also was a friend of and to man—individually and collectively. He put the mirror up to life, but he had a concern for the welfare and happiness of mankind, and for his own future: "Mother dear—I also wish to do great works of art—to write great good poems—to help the poor and the unhappy—I also wish to be happy myself, but young as I am who shall say that I will not be a failure."[1]

Williams's attraction to writing was early and powerful: "At the University of Pennsylvania in 1902, I enjoyed the study of medicine, but found it impossible to confine myself to it. No sooner did I begin my studies than I wanted to quit them and devote myself to writing."[2]

Williams also had tugs toward art and painting from his earliest days:

> I know now that Mother was not aware of the great names, Cezanne, Van Gogh, Gauguin, or anything of the rumors of the great exhibitions at the galleries of those years. She was no more than an obscure art student from Puerto Rico, slaving away at her trade which she loved with her whole passionate soul, living it, drinking it down with her every breath—the money gone, her mother as well as her father now dead, she was forced to return with her scanty laurels, a Grand Prix, a few gold medals to disappear into a trunk in my attic, a few charcoal sketches, a full-length portrait of herself, unfinished by that Ludovic, showing her ungainly hands.[1]

But it was Charles Demuth, an art student at Drexel Institute, who had a great influence on Williams. As Williams wrote: "I met Charles Demuth over a dish of prunes at Mrs. Chain's boarding house on Locust Street and formed a lifelong friendship on the spot with dear Charley, now long since dead. For I was still undecided whether or not I should become a painter. I coldly recalculated all the chances."[2] And, Demuth was influenced by Williams: "Demuth was a painter who nursed ambitions of becoming a writer; often his paintings took literary works as their subjects, and later he illustrated works by Zola, James, Proust, and Poe. Williams encouraged Demuth to write and was encouraged by him."[3]

It was a remarkable relationship that had its birth in the college years and never ended until Demuth died of the complications of diabetes:

> In spring among the back streets, when supper would be over and we felt disinclined to return to our rooms, Charley Demuth used to take long walks with me in West Philadelphia (where Grandma Wellcome, my father's mother, had just come to live). There was a high brick wall along the south side of Locust Street, just west of Thirty-sixth, inside of which there must have been an old garden, long neglected. The thought of it fascinated me. Charley laughed when he spoke of it. 'Not many could enjoy such a thing as that,' he said, 'by merely looking at the outside of a wall.'[2]

After graduation from college, Demuth and Williams kept in touch and used the work of the other for creative stimulation. Demuth's family finances were such that he was able to travel to Europe frequently after his first trip at age 20 (in 1904): "He wanted to travel even more frequently and might have become an expatriate were it not for his precarious health, relegating him to the care of his mother in the family home in Lancaster, Pennsylvania. He had to adjust to the situation by various stratagems. His watercolors and still lifes were a concession to his physical weakness brought on by his diabetes."[4]

*Dr. Krosnick is Editor, *The Journal*, MSNJ, and a diabetologist with a practice in Trenton.



Figure 1—*I Saw The Figure 5 in Gold.* Charles Demuth, 1928. Grateful acknowledgment is given to The Metropolitan Museum of Art, The Alfred Stieglitz Collection, 1949.



Figure 2—*Flowers.* Charles Demuth, 1915. Grateful acknowledgment is given to The New Jersey State Museum Collection, Trenton. Purchased by the Friends of the New Jersey State Museum with a gift from Mary Lee Johnson, 1974.

Williams, always "the country doctor," worried about his friend: "Poor old Charley Demuth, this was before the days of insulin and he was dying of diabetes. His studio then was the third front in one of the buildings of Washington Square South. He called me there one day to see him. He wanted me to inspect his back, which looked as though a young tiger had clawed it from top to bottom. They were deep, long digs, recently scabbed over. Charley was 'worried about infection.' "[2]

Demuth's last trip to Europe was in 1921, "Upon his return to this country, Demuth was in bad shape. That, I think was when I first saw his mother. She was a horse of a woman, a strange mother for such a wisp of a man; he was lame, tuberculous, with the same sort of chin as Robert Louis Stevenson and long, slender fingers. He had an evasive way of looking aslant at the ground or up at the ceiling when addressing you, followed by short, intense looks of inquiry."[2]

The latter problem with his vision may have been the result of diabetic retinopathy; such patients may have maculopathy and/or rapid swings in visual acuity, which require greater dependence on peripheral vision.

Demuth, undoubtedly, had the type of diabetes we now call type I or insulin-dependent diabetes, but unfortunately this was the preinsulin era. His condition—diabetes, tuberculosis, and probably diabetic neuropathy—was deteriorating, but two fortunate events occurred:

> Dr. Allen opened a sanitorium for the dietary treatment of diabetes at Morristown that year. Demuth was one of his first patients. His intake was reduced to the caloric minimum. The result was frightening. Charley faded to mere bones, but he was able to live. They occasionally permitted him to be taken home to us for a short visit, but I had to return him the same evening. He brought with him a pair of scales and weighed his food carefully. I never saw a thinner, active person (this, as I say, was before the discovery of insulin), who could stand on his feet and move about.[2]

Who was this Doctor Allen? Frederick M. Allen, M.D., was a remarkable scientist, researcher, teacher, and clinician who established the Physiatric Institute in June 1920, in Morristown. Dr. Allen, who later was awarded the Banting Medal by the American Diabetes Association (1949) after a "lifetime of service to diabetes" also was bestowed the plaudits of the greatest scientists in the field of diabetes, including Charles H. Best and Sir Frederick Banting, codiscoverers of insulin. Dr. Best said, "The clinical program which he [Allen] developed, enabled diabetics to live, so that many of them secured benefits from insulin. I feel strongly that Dr. Allen never received full credit for his fundamental work in diabetes. Certainly, Banting and I used his book [Glycosuria and Diabetes] almost as a bible in the development of the work on insulin and we felt deeply obliged to him."[5]

On July 27, 1921, Sir Frederick Banting was able to write the following. "We had a depancreatized dog and we decided to begin treatment. . . . Five cc of this extract was administered intravenously into the depancreatized dog. Samples of blood were taken at half hour intervals and showed that the blood sugar had fallen from 0.200 to 0.11 percent in two hours. The clinical condition of the dog was markedly improved."[6]

The first patients were treated with the pancreatic extract which was called insulin at the Toronto General Hospital on January 11, 1922. Dr. Frederick Allen was the third physi cian to use insulin in the United States at the Physiatri Institute on August 10, 1922. Demuth was one of Allen's 16 patients treated with insulin by May 1923, which "com prised the largest series treated with insulin to that time."[3]

Williams wrote, "I visited Demuth several times while h was in Dr. Allen's sanitorium. . . . Insulin came in just th nick of time to save Charley from dissolution."[4] And later Dr. Williams changed his gloomy prognosis of earlier days i a letter to Marianne Moore dated, August 23, 1928. "De muth is very well, as well as a man can be who has to hav two hypodermic injections every day of his life and whos food must be weighed at every meal. His mother is a patro saint. He will live as long as we will."[4]

Dr. Williams miscalculated, for his friend died seven year later of diabetes. But, what productive years! In 1922, whil undergoing insulin therapy in Morristown, Demuth painte his watercolor, *Tuberoses.* He previously had complete *Machinery* (1920), which he dedicated to William Carlo Williams and *End of the Parade—Coatesville, Pa.,* whic Williams purchased from the Daniel Gallery. In 1927, De muth executed *My Egypt* and in 1928, he painted, *I Saw Th Figure 5 in Gold* (Figures 1 and 2) which was based o Williams's poem, "The Great Figure." In 1930, Demuth painted *Distinguished Air* and *Buildings, Lancaster.** Wil liams wrote:

> He always called me Carlos and once painted a 'literary' picture around my name and a poem I had written to "The Great Figure" (the figure 5 on the side of a fire truck in wild transit through the New York streets). Once on a hot July day coming back exhausted from the postgraduate clinic, I dropped in as I sometimes did at Marsden's studio on Fifteenth Street for a talk, a little drink maybe, and to see what he was doing. As I approached his number I heard a great clatter of bells and the roar of a fire engine passing the end of the street down Ninth Avenue. I turned just in time to see a golden figure 5 on a red background flash by. The impression was so sudden and forceful that I took a piece of paper out of my pocket and wrote a short poem about it:[2]
>
> Among the rain
> and lights
> I saw the figure 5
> in gold
> on a red
> firetruck
> moving
> tense
> unheeded
> to gong clangs
> siren howls
> and wheels rumbling
> through the dark city.**

My Egypt, Buildings, Lancaster, and *Distinguished Air* are in the Whitney Museum of American Art. *Tuberoses* and *End of the Parade —Coatesville, Pa.* are in private collections. *Machinery* and *I Saw The Figure 5 in Gold* are at the Metropolitan Museum of Art.

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he details of Demuth's death are not germane, but he
l in October 1935, of diabetes-related complications.
ording to Dr. Williams, "He was careless and died later
way while on his way home to Lancaster, either from lack
insulin or an overdose; I was never able to get the
wer."[2]

"It was Charles Demuth, an art student, who had a great influence on Williams. It was a remarkable relationship that had its birth in the college years."

And neither will we, but it is probable that he did not die
either a lack or an overdose of insulin enroute to his home.
dds favor the probability that Demuth, an insulin-depen-
ent patient with diabetes for 15 to 20 years, died at age 52
a sudden vascular catastrophe such as an acute myocardial
farction.

On the occasion of Demuth's death, Marsden Hartley
rote, *Farewell Charles, an Outline in Portraiture of Charles
emuth—Painter.*[7] Williams, like all physicians, was used to
eath, but he was moved to write a poem, "The Crimson
yclamen, To The Memory of Charles Demuth."

Biographer Paul Mariani considers Williams's description of the life cycle of the house plant, the crimson cyclamen, as a remarkable elegy, "And yet, despite the relentlessness with which Williams focused on the plant before him—one gradually becomes aware that what is being treated here is the whole of the artist's life in this meditation on the flower—Williams's own life as well as Demuth's."[17]

William Carlos Williams, physician and poet, and Charles Demuth, painter, were born in the same year. They made an indelible mark on each other and on the world of letters and the visual arts. ■

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The Raper from Passenack*

WILLIAM CARLOS WILLIAMS, M.D.

was very kind. When she regained
her wits, he said, It's all right, kid,
I took care of you.

What a mess she was in. Then he added,
You'll never forget me now.
And drove her home.

Only a man who is sick, she said
would do a thing like that.
It must be so.

No one who is not diseased could be
so insanely cruel. He wants to give it
to someone else—

to justify himself. But if I get a
venereal infection out of this
I won't be treated.

I refuse. You'll find me dead in bed first. Why not?
That's
the way she spoke,

I wish I could shoot him. How would
you like to know a murderer?
I may do it.

I'll know by the end of this week.
I wouldn't scream. I bit him
several times

but he was too strong for me.
I can't yet understand it. I don't
faint so easily.

When I came to myself and realized
what had happened all I could do
was to curse

and call him every vile name I could
think of. I was so glad
to be taken home.

I suppose it's my mind—the fear of
infection. I'd rather a million times
have been got pregnant.

But it's the foulness of it can't
be cured. And hatred, hatred of all men
—and disgust.

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J-9043-4 July 1981

ORIGINAL ARTICLE

William Carlos Williams: The Doctor

WILLIAM A. CALDWELL*

It would be easier to resent and resist the proposition that William Carlos Williams was a couple of other guys, separate and sovereign, except that he himself endorsed it. In spite of that, resentment and resistance kept coming up.

He never went quite so far as did the mutterers of faint praise in the arts and sciences—the smug Eliots who put down the poet as a sort of hayseed Grandpa Moses, and his professional peers who regarded a medical practice in the suburbs as rather a cop-out. To be there when and where one was needed was all very well but scarcely the big time.

Yet, it appears that in his own opinion, Williams led two lives. About that I'll dare to argue, as I didn't at the time.

It was mid-June, 1934. Another young reporter, Verb Amber Gabbert of the *Bergen Evening Record*, had come to interview him, as young reporters in their brief generations did and kept doing through the years. He was good copy, this poet-physician, this pediatrician-prophet. He was exquisitely courteous. He told funny stories, some of them printable. He had a way of making young people sense that they were important to him and that we had a lot in common, such as the lonely search for the word most accurately conveying any reality, such as a man's searching in his gut for the courage to find the truth about this truth.

The evening's last patient having been seen and bade goodnight, Dr. Williams loosened his necktie and leaned back at his desk and lit a cigarette that would burn unsmoked until the coal nipped his fingers. Time to deal with young Gabbert's first question.

"How could a man be both a doctor and a man of letters —poet, novelist, playwright, critic, librettist, publisher, and then some?"

"No problem," said Dr. Williams, "because, I am not both. I'm first one, then the other. I separate my practical and my literary lives."

It was in the course of that conversation a half-century ago that Dr. Williams disclosed to Verb Gabbert his secret birth control formula. The failproof contraceptive. What the world was waiting for. As follows: One glass of water. "Before sexual commerce?" "No." "After?" "No." "Well, during, for God's sake?" "Instead," sighed Dr. Williams. I do not think this material has been previously published.

In his report on that interview Gabbert did blow a secret that Dr. Williams would just as soon have left suppressed. It was about the prescription blanks.

"I write," Williams said, "whenever I have nothing else to do whether that interval is a minute or ten minutes or an hour. What is there to stop me? There is a fountain pen. Here are prescription blanks."

He raised the green blotting pad from his desk. There were the prescription blanks. Between patients he would jot on the back of the blanks some line or image that had just flickered into consciousness and would flicker away unless impaled.

Everyone knows now what became of this timber. He would take the prescription blank scribbles to the home of a Rutherford woman with whom he had struck a bargain years before. If she would type his manuscripts, Dr. Williams would take care of her children. She would bat out a clean copy. He would edit that, sharpening a verb here, inserting a line more precisely vernacular there, and would reduce it to a finished product.

The literary world had come to respect Dr. Williams. It did not buy him.

He was grateful for the attention the *Bergen Evening Record* and Gabbert had paid to him—"A teasing bit of journalism," he considered the piece.

And would Gabbert get someone—he must have intuited that there's a ghostly someone in every newspaper office, as in every hospital or school, who has nothing much to do but mind the store—to send him a couple of prints of the picture for which he sat in lean Byronic profile to illustrate the piece.

"I enjoyed reading it," he wrote to Verb Gabbert. "In spite of the way you got me in wrong with the pharmacies by giving away the use to which I put their prescription blanks. Now that's what I call a sentence.

*Mr. Caldwell is a retired, prize-winning writer of the *Bergen Evening Record.*

"Lord! I hate to do this, but I've got to ask you to send me some copies of that *Bergen Evening Record* if there are any about. I want one for my dear old pal Ezra Pound, one for my wife's mother, no, two for her, one for my own mother and one for my secretary. That makes five in all. Would you have someone do that for me? I won't bother you again."

Then, under the elegantly rounded signature of a man who at one time meant to be a painter: "P.S. Naturally, I expect a bill for the above."

I did not know Dr. Williams, and let's not get into the question whether anybody, including himself, knew the congregation of geniuses that ambled about in that suit of clothes. But, to say I was acquainted with one William Carlos Williams, M.D., needn't be a case of deceptive labeling. That one was the family practitioner who, well, cared.

This is not to propose an invidious distinction between the old-fashioned general practitioner who made house calls and the present generation of physicians. They care or they would not be there. Would it be offensive to suppose he knew how to say things hurt and there's not one hell of a lot anybody can do about it?

To be able to do no more than be there troubled him. He guessed once he had brought 3,000 babies into the world. He wished he could help. He tried. One night, a half-century ago, a young reporter called me and said her sister's baby was running a high fever and having trouble breathing. She asked if I knew any doctor who might come to a house on the wrong side of the tracks? The baby's father was out of work, but there were relatives and they would try to pay. So I phoned Dr. Willams, and he said of course he would go—that was what he was here for, and thanks for letting him know. At two o'clock on a bitter winter night, he went out into the dark mean streets and found the house where the baby lay, and it all turned out all right. It was a Christmas story, but I never had the wit or guts to write it.

Memory is an untidy record keeper. We pilgrims to the Ridge Road shrine would swap stories about him and then inhabit them.

What did his community think of him? You can get an idea from the fact that when the autobiography was published in 1951, the Rutherford Chamber of Commerce had to limit to 400 the reservations for a luncheon in his honor and the chairman of the proceedings introduced him as Dr. Bill, period.

That was the day he wept.

They had given him a copy of the autobiography in fragrant red morocco, and he rose to accept it. The 400 people stood and cheered, and suddenly there he was talking away in that high almost uninflected voice about what the artist means to the community and vice versa. "All that remains of communities and civilizations," he said, "all that remains of their worth and dignity exists in the art they leave. That is my excuse for existence."

There was more, and I'll vouch for the memory's accuracy because I was there and took notes.

"All art must arise from a locality, it must come from the people in a locality. The artist's puffing himself out so that he has an existence away from his locality I cannot understand. The artist must disappear, disappear into his work, so that only the work exists. To the extent that he does that, the work can be great, and that's what is great about it."

He looked around him and said, "Your lives, your problems, are the things that make the artist go. The things you hide in your hearts and cannot tell about, even to yourselves that makes art. I've come to know some of the things tha make people great."

He was looking into the upturned faces again, and in his own lean face was something like wonder.

"You see," he began, then stopped, then resumed, "you see, you are here for a good purpose, even if I am the recipient of the purpose. You are doing a warm thing in your hearts, and my heart is warmed. You are united, together, in . . . . That is the greatest thing."

"Damn if it don't sound like *Paterson, Book 1,*" a man muttered, and was duly kicked under the table. Dr. Williams couldn't go on. He sagged back into his chair at the head

"He was the family practitioner who, well, cared. He guessed once he had brought about 3,000 babies into the world."

table and buried his face in his hands, and the part of his face you could see outside his hands turned pink and his shoulders shook. Everybody in the room was dabbing the glimmer off his eyes. Something about love had been said. The poet had made his point, never mind how.

How he thought of his community and its people is a matter of record. The artist derived his greatness from the community and his community derived its immortality from him. They were one and inseparable.

He thought intensely. He paid attention. Simplify, simplify, cried his counterpart Thoreau, as if there were anything simple about anything, and Williams did:

so much depends
upon
a red wheel
barrow
glazed with rain
water
beside
the white chickens*

He would write of things like apple trees whose blossoms touch the sky, but his mind was on the people who were his soil, and he wrote of crusted grime and niggers and Jews and skinny pot-bellied Polacks in their own language and on their own terms. "Ignorant people use the most idiotic words sometimes with a dignity, a force of feeling, that makes them glow and flare," he said to someone who wanted explanations. "I listen in profound silence. Later I try to imitate. I almost always fail."

To the people whose language he did not often fail to transfix on a prescription blank, he was Dr. Bill, town physician, P.T.A. president, chairman of charity fund campaigns, about as enigmatic as the boots he'd put on to go help look for someone missing in the green desert of the Meadowlands. "Why, it doesn't embarrass me in the least that my writing might—undoubtedly does—appear goofy to my fellow townsmen," he said. "I am their doctor and their

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neighbor, not their writer."

More than once he said he became a doctor because he didn't hanker to starve as a writer. "I could never see dying for art," he said. "I'd rather live for it."

And yet, in the last lines of his autobiography he professed an indifference to his somatic person: "What becomes of me has never seemed important, but the fate of ideas living against the grain in a nondescript world has always held me breathless."

Someone calculated that in his lifetime he was known by name to not more than 1 in 100 people in the community. On the second anniversary of his death, a young reporter asked after him through the Paterson on which Williams had conferred the kind of dignity another poet once conferred on a small town in Asia Minor—to wit, life everlasting—and came back to write that he was forgotten.

"And yet I know," Dr. Williams said years before, "that the final judgment on my work is my own."

Something must be said about integrity. Something must be said about the man who would stop his car on the road to the isolation hospital at Bergen Pines and get out and see what was there—shacks, sparrows, flowers, chickens—see them, see them as they had not been seen before. That wasn't a poet-doctor, nor was the man stumbling through the night to bring compassion to a woman's bedside as a doctor-poet. He was one and indivisible.

There's something called integrity, and it isn't the self-conscious virtuousness politicians attribute to themselves. The first meaning of integrity, the meaning whose priority is herewith arbitrarily declared, is wholeness, consistency, oneness. Because it is expected of us, by ourselves if by nobody else, we do the best we can, and if it is good we know it isn't good enough. It has been going on for a few billion years now. It works.

And what did he think of this one among his many communities? When, after his retirement because of illness in the 1950s, the Bergen County Medical Society unanimously elected him an honorary member, Dr. Williams did a little summing up:

"I am proud to have been a physician. This is my home, and whatever I have achieved stems from the conviction that in the United States we speak our own language, not just English. This is my inspiration. The American idiom is my forte, and I am proud to be known as a poet and proud to have been a doctor."

He led one life. It was his greatest poem. ■

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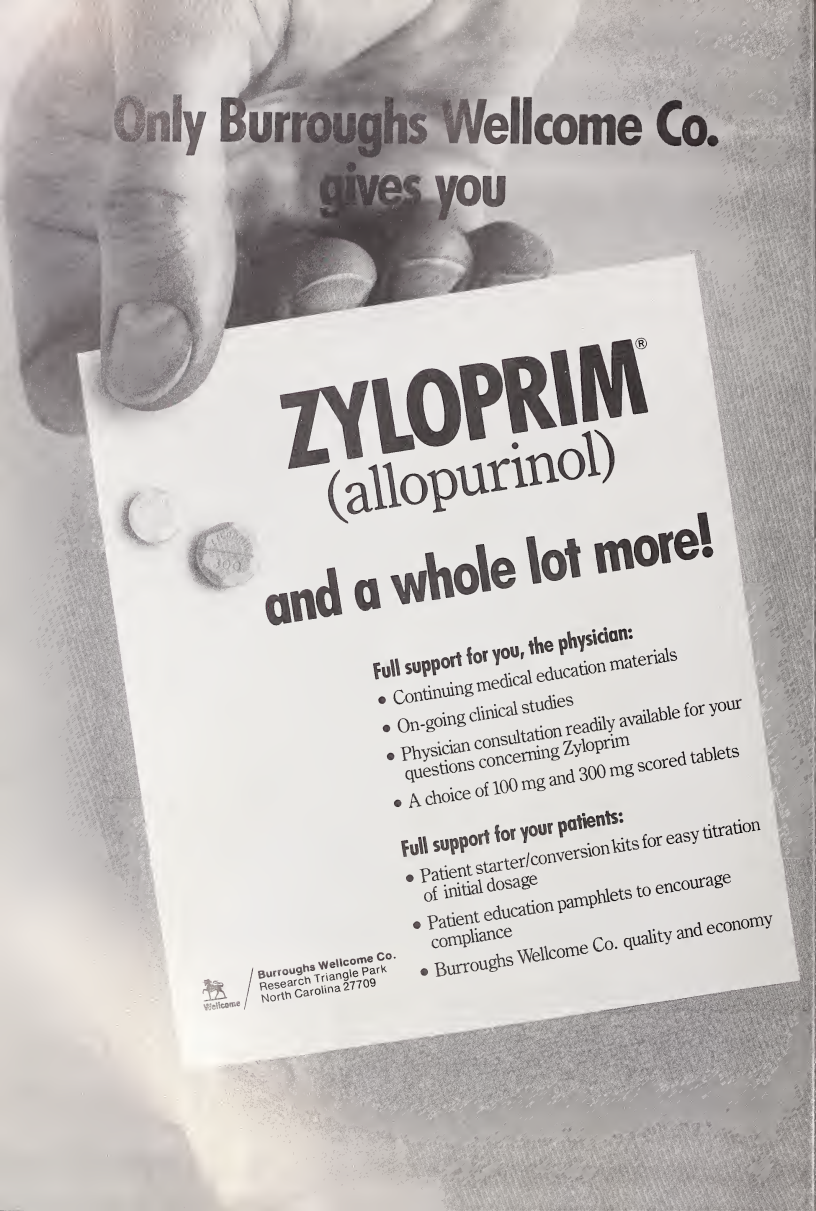
Blue Shield
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The Widow's Lament in Springtime*

WILLIAM CARLOS WILLIAMS, M.D.

Sorrow is my own yard
where the new grass
flames as it has flamed
often before but not
with the cold fire
that closes round me this year.
Thirty-five years
I lived with my husband.
The plumtree is white today
with masses of flowers.
Masses of flowers
load the cherry branches
and color some bushes
yellow and some red
but the grief in my heart
is stronger than they
for though they were my joy
formerly, today I notice them
and turned away forgetting.
Today my son told me
that in the meadows,
at the edge of the heavy woods
in the distance, he saw
trees of white flowers.
I feel that I would like
to go there
and fall into those flowers
and sink into the marsh near them.

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ORIGINAL ARTICLE

William Carlos Williams: The Influence of a Medical Practice

WILLIAM B. OBER, M.D.*

Rutherford, New Jersey, might be called a representative town in the midatlantic region, near enough to a metropolis to provide cultural amenities, yet separated enough by geography to have a life and character of its own. Though it may be difficult to reconstruct in one's imagination what Rutherford was like in William Carlos Williams's boyhood, it is not so difficult to reconstruct the circumstances under which he practiced medicine and wrote his poems, short stories, novels, plays, and literary essays. His own *Autobiography*, published a dozen years before he died, is a convenient source. Fortunately for his readers, he wrote it with the ear of a man of letters rather than a literary historian. For the details of literary history coupled with the human and humane side of the man, one can turn to Reed Whittemore's sympathetic and invaluable biography, the tribute of one fine poet and critic to another.

The basic biographical facts are clear enough. Born in Rutherford in 1883, Williams was educated there and attended secondary school in Manhattan. He went directly to medical school at the University of Pennsylvania and received his medical degree in 1906. There he met Ezra Pound who influenced him to write and whose friend and champion in adversity Williams remained all his life. Williams returned to New York for further training—a year's internship at French Hospital, then a year at Nursery and Child's Hospital, both of which now are defunct. Between his hospital years and starting a practice, he took an extended tour of Europe, visited Pound in England, and met Yeats and other literary figures. He started practice in 1910 using the kitchen pantry of his parents' house; the front hall was the waiting room. His first book, a paperbound pamphlet titled *Poems*, had already appeared in 1909; four copies were sold at 25¢ each. His practice increased; by the end of 1912 he was able to marry and set up light housekeeping next door. The next year, when his wife was seven months pregnant, they bought the commodious home at 9 Ridge Road that was to serve as their home and his office for the next 50 years (Figure 1).

At this point it is necessary to clear up a misconception. Many writers refer to Williams as a pediatrician. This is only partly true. He did have one year of specialized training in pediatrics, and certainly he was an effective, sympathetic doctor for children. But, in 1913, there were no "specialists" in Rutherford. A doctor had to take care of almost every patient who came to his office. Williams was a "family doctor" in the best sense of the term. A majority of his patients may have been children and pregnant women, but he saw others as well. He kept late office hours for his working class patients, took care of their injuries, and even did a bit of minor office surgery. He made house calls. His patients were well looked after. They liked and trusted him, and he cared for them.

In any event, the American Board of Pediatrics was not founded until 1933 when Williams had been in practice for over two decades. Not until 1948, when his elder son William Eric Williams, M.D., fresh from a pediatric residency at New York Hospital, joined his father's practice did it take on an almost exclusive pediatric slant.

William Carlos Williams retired from active practice in 1952 following his first stroke. He died in 1963 after a decade of slow physical decline, but that decade was marked by widespread recognition of his contribution to American literature in our century, many public honors, and a general acceptance that he was a physician who had achieved great things outside of medicine.

What Williams claimed for himself as a physician-writer was a unique insight granted to a humane practicing physician with a literary gift. "My 'medicine' was the thing that gained me entrance to (the) secret gardens of the self. . . . I was permitted by my medical badge to follow the poor, defeated body into those gulfs and grottos. And the astonishing thing is that at such times and in such places—foul as they may be with the stinking ischiorectal abscesses of

*Doctor Ober is Director Emeritus, Department of Laboratories, Hackensack Medical Center.

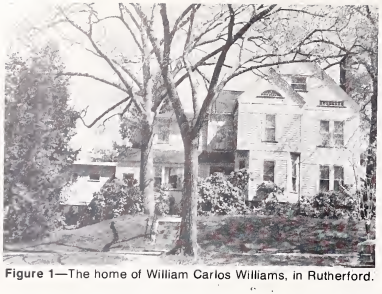


Figure 1—The home of William Carlos Williams, in Rutherford.

our comings and goings—just there, the thing in all its greatest beauty may for a moment be freed to fly for a moment guiltily about the room. In illness, in the permission I have as a physician . . . to be present at deaths and births . . . just there—for a split second—from one side or the other, it has fluttered before me for a moment."*

In 1920, he published *Kora in Hell: Improvisations,* now recognized as a seminal work of avant-garde prose for the period just after World War I. The cover was designed by Williams himself and later he wrote about it: "The cover design? It represents the ovum in the act of being impregnated, surrounded by spermatozoa, all trying to get in but only one successful. I myself improvised the idea, seeing, symbolically, a design using sperms of different breeds, various races let's say, and directed the artist to vary the shadings of the drawing from white to gray to black. The cell accepts one sperm—that is the beginning of life. I was feeling fresh and I thought it was a beautiful thing and I wanted the world to see it."

Just how many physicians or biologists bought the book and recognized the drawing for what it was is debatable, but they probably were few. Just what the drawing meant to literary folk who were innocent of reproductive biology likewise is problematic. But, if only a handful of readers got the point, that was enough for Williams. A good idea does not need a wide audience when it first is presented. Its merits will win the day later on, as Williams was to find out when, late in life, there was recognition of his literary value.

One question often put to a busy doctor who writes and publishes voluminously—Williams published about 40 books of prose and poetry—is "How do you find the time?" To this tiresome conversational gambit Williams's reply was: "Five minutes, ten minutes, can always be found. I had my typewriter in my office desk. All I needed was to pull up the leaf to which it was fastened and I was ready to go. I worked at top speed. If a patient came in at the door while I was in the middle of a sentence, bang would go the machine—I was a physician. When the patient left, up would come the machine. My head developed a technic. . . . After eleven at night, when the last patient had been put to bed, I could always find the time to bang out 10 or 12 pages. In fact, I couldn't rest until I had freed my mind from the obsessions that had been tormenting me all day. Cleansed of that torment, having scribbled it away, I could rest."

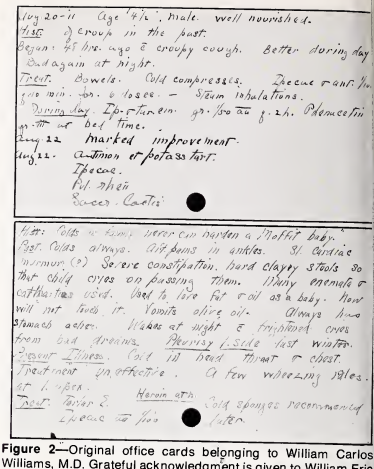


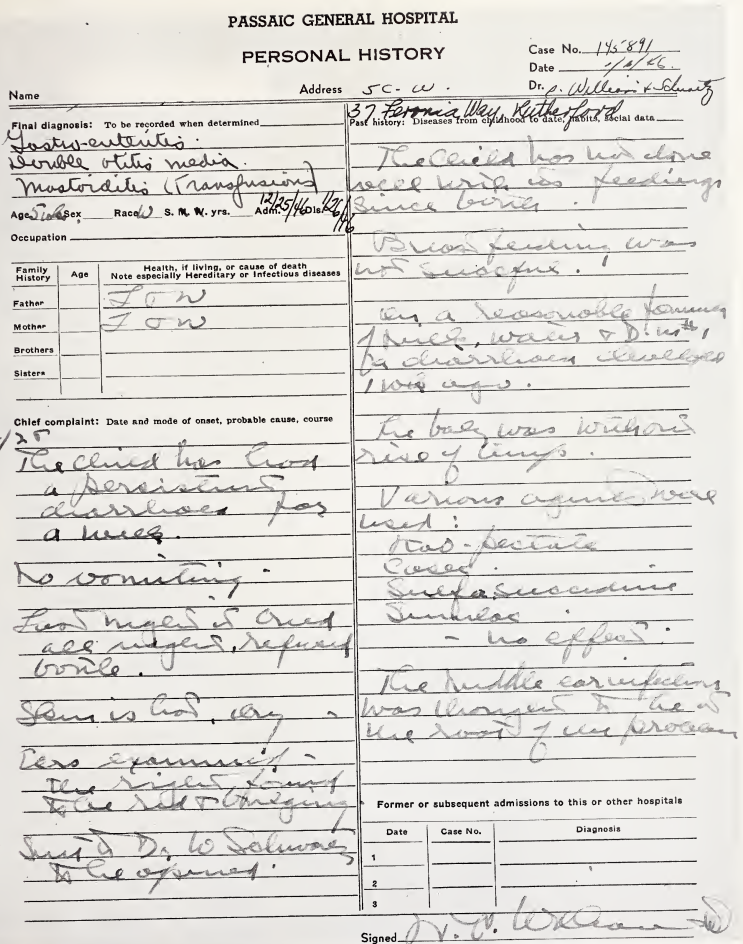
Figure 2—Original office cards belonging to William Carlos Williams, M.D. Grateful acknowledgment is given to William Eric Williams, M.D., for permission to reproduce the cards.

One of his poems, "Le Médecin Malgré Lui,"* takes the title from Molière's comedy and applied to himself and his own lifestyle:

Oh I suppose I should
wash the walls of my office
polish the rust from
my instruments and keep them
definitely in order
build shelves in the laboratory
empty out the old stains
clean the bottles
and refill them, buy
another lens, put
my journals on edge instead of
letting them lie flat
in heaps—then begin
ten years back and
gradually
read them to date
cataloguing important
articles for ready reference.
I suppose I should
read the new books.
If to this I added
a bill at the tailor's
and at the cleaner's
grew a decent beard
and cultivated a look
of importance—
Who can tell? I might be
a credit to my Lady Happiness
and never think anything
but a white thought!

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*Grateful acknowledgment is given to New Directions Publishing Corp. for permission to reprint "Le Médecin Malgré Lui" from *The Collected Earlier Poems of William Carlos Williams* (copyright 1938 by New Directions Publishing Corp.).



PASSAIC GENERAL HOSPITAL

PERSONAL HISTORY

Case No. 145891
Date 1/6/46
Dr. J. Williams & Schmitz

Name
Address 5C. W.

Final diagnosis: To be recorded when determined
Gastro-enteritis.
Double otitis media.
Mastoiditis (Transfusion)

Age 36 Sex Race W S. M. W. yrs. Adm. 12/25/46 Dis. 1/6/46

Occupation

Family History	Age	Health, if living, or cause of death Note especially Hereditary or Infectious diseases
Father		Ill
Mother		Ill
Brothers		
Sisters		

Chief complaint: Date and mode of onset, probable cause, course
12/25
The child has had a persistent diarrhoea for a week.
No vomiting.
Feed urgent & Oral acc urgent. Refused bottle.
Stools is bad, very -
Pers examined -
The right tonsil is red & enlarged
Seen by Dr. W Schwarz, & he agrees.

Past history: Diseases from childhood to date, habits, social data
37 Parsonage Way, Kettle Ford
The child has not done well with its feedings since birth.
Birth history was not suspect.
On a reasonable formula & Vits & Diet, for diarrhoea developed 1 wk ago.
The baby was without rise of temp.
Various agents were used:
Kaol-pectate
Casec.
Sulfasuccadine
Sulfas.
- no effect.
The suitable corrections was thought to be the root of the problem

Former or subsequent admissions to this or other hospitals

Date	Case No.	Diagnosis
1		
2		
3		

Signed W. W. Williams M.D.

Figure 3—A handwritten medical record of William Carlos Williams, M.D., 1946. Grateful acknowledgment is given to William Eric Williams, M.D., for permission to reproduce this record.

It is easy to visualize Williams at his desk one evening after the last patient had gone, looking around his office and taking inspiration from the casual disorder, wryly contrasting his environment and his interests with those of his fellow practitioners (Figure 2 and 3). Perhaps we can consider ourselves lucky that only rarely did he think "a white thought." But he never felt he was miscast as a physician. He may have grumbled a bit at the long hours, patients' outrageous demands, the unreasonableness of disease, and the body's response, but he continued to practice as long as his strength allowed.

In 1938, Williams published four short stories that transform the experience of bedside medicine into art. One of the stories, "A Face of Stone," describes a working class couple

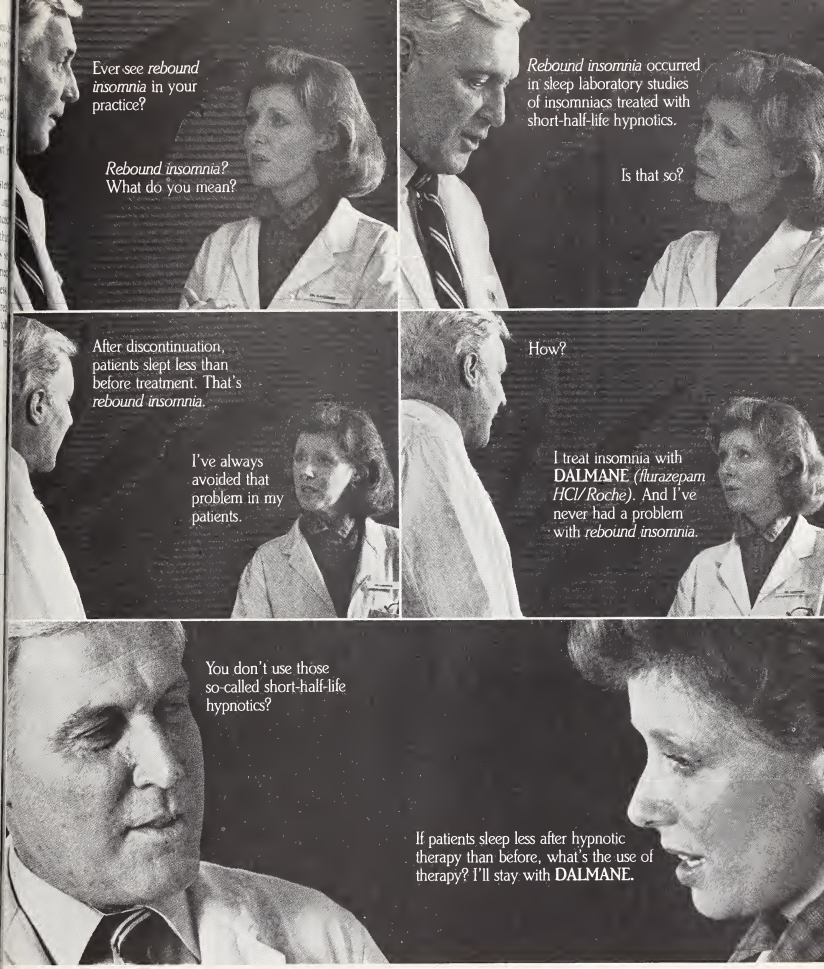
Williams's ignorance of child-rearing is appalling. The young mother does not even know how to wean her child. As a child in Poland she had rickets, yet she wears fancy, flimsy high-heeled slippers. As in Chekhov, "nothing happens," but one sees a vignette of ordinary American reality as Williams gives her some pills for the pain in her leg and for her varicose veins: "Then for the first time since I had known her a broad smile spread over her face. Yeah, she said, I swallow him."

One of the stories is tragic. "Jean Beicke" tells of an 11-month-old girl who dies of purulent meningitis secondary to mastoiditis, a scrawny, undernourished infant whose father has decamped. Williams's ear for the accents of everyday speech was faultless, and he tells the story in the neutral tone of a detached observer who is carefully trying not to let his sympathy intrude. One senses that the incident was real; the description of the autopsy is a faithful recollection. One speculates how long before 1938 the event took place. It seems to date from his hospital years in 1909 to 1910, and the pain and toughness lay in his mind for a quarter of a century before he wrote the story.

Perhaps these medical stories furnish the physician-reader with the most direct access to Williams's literary world. Simple and unaffected in style, even unadorned, they communicate directly without self-conscious "literary" effect.

Williams owes something to his predecessors, Anderson and Hemingway. One can see in his medical stories as well as in his poems the emphasis on the substantive, the image as perceived, and as we recall his maxim: "No ideas but in things."

The ideas as well as the emotions attached to them stem directly from the "things" he described so clearly and objectively. The simplicity is deceptive, and inexperienced writers have had to learn the hard lesson of attempting that style: It's not what you put down on paper that counts so much as what you cross out. Unlike Chekhov who claimed that medicine was his lawful wife and literature his mistress, Williams saw no such distinction: "Medicine never interfered with me. It was my very food and drink, the very thing which made it possible for me to write. Was I not interested in man?" ■



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WILLIAM CARLOS WILLIAMS, M.D., Rutherford

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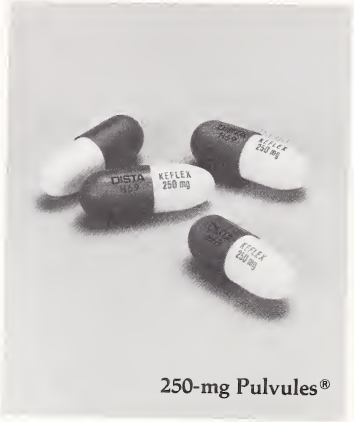
in which shine
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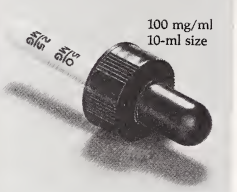


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ORIGINAL ARTICLE

William Carlos Williams: Physician and Poet

AVRUM L. KATCHER, M.D.*

By what native talent and training do some rare persons achieve excellence in multiple vocations not obviously related? William Carlos Williams had two different careers: as a writer and as a physician practitioner. But they interlock! In the poems, stories, and novels we find people—how they are and as they are. We have no comparable records of his doctoring, but as Helen Williamson Fall has recorded in her reminiscences reproduced below, and as others in this issue testify, there is a warmth and a compelling concern with quality. And what else is the art of medicine, if not the ability to fuse the pattern of health—or sickness—with the person who has that state of health—or sickness? So it must have been that the poet who insisted on the importance of the image (the thing) brought back to the privacy of the consulting room, an eye sharp for images and things. And the poet who was a doctor displayed an intense awareness of what was best, and a tart disgust with unnecessary waste. Thus, from a letter in 1938:

> Just had a nice, big, fat young woman in here, age 41—the place still smells of her, not too objectionably so long as you know where it comes from —she has a pain in her coccyx and her poor head feels (as mine does) as if it were packed with cotton. . . . Her difficulty comes from a fibroid tumor of the uterus which makes her periods irregular and dotty. She doesn't want to go to the H. hospital because her sister died there two years ago. The sister had a bad heart and her doctor wanted her to get rid of it in the second month, but the husband was religious (O God! give me relief from my afflictions!) and didn't think it was right. So she said to herself, lots of times doctors tell women they should not have any children and after that they have five or six and it never bothers them. So she went ahead with it, and in the seventh month she began to swell up something awful. You wouldn't know she was a young woman. She swelled up to twice her size and all she could do was sit up in a chair and gasp. The doctor wouldn't take her case, but he felt sorry for her, so he got a specialist from the city to help him. When she couldn't go any longer, they had to do a caesarean section, but she died on the sixth day. Now I feel better. I am always better when I can spill my stupid soul into the emptiness—with someone foolish enough to stand below my window and perhaps get it on his coat."**

How did Williams do it? A horse for work, his son said: "He didn't need any sleep; he could go with three or four hours of sleep a night." Perhaps Williams was temperamentally highly active, probably intense in his responses, and certainly adaptable and open in his approach to new persons, new situations. He was capable of switching on and off like a light from his medicine to his poetry and back again—writing on scraps of paper and prescription pads while waiting in the car for traffic lights. Pulling a typewriter out from the foldaway shelf in the desk between patients. He was stimulated by people, by things, and by words: "I want to be drunk and I'm beginning to feel drunk. With the only drink I know that intoxicates me: words at flow. My own words pouring out of me, the steam of them rising and the sound of them splashing in the bowl—even the rank smell of them rising as if from the green shell of a walnut. Nuts!"

The poet who was a doctor possessed as John Ciardi elsewhere in this issue has stated "A passionate energy . . . massively poetic gift."

The doctor who was a poet wrote about his work as in agreement with Sir James Spence: "The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it."

*Dr. Katcher is Director, Pediatric Services, Hunterdon Medical Center, Flemington. Dr. Katcher is serving as Guest Editor of this special commemorative issue.

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Whether a doctor writes a poem, or a poet treats a patient, the writing of poems shares with the treating of patients certain attributes, among others: the exercise of a particular set of abstractions of thought limited by accepted modes of reasoning, the use of a specific language, the adoption of certain routes to convey information, and the selection of a target individual to be influenced. There are technical requirements to perform the task, and talent is modified by experience over a period of years. For both, the subject of the thought and skill to an extent becomes an object to be thought about or worked upon. The poet-doctor or doctor-poet will develop a base of information on the subject-object, consider that information, mentally prepare an evaluation or assessment, and then in a manner felt to be creative by the poet and rational by the doctor prepare a result—the poem or the plan of medical management.

For the poet, the products of thinking, in the words of Ciardi, are: "A formal context for releasing more meaning/perception/feeling that can be overtly stated." Without the embodied affect, the poem has no significance; it becomes a shell. Williams once said: "No meaning but in things," because he felt, in addition, that without the subject, (the object) upon which thought was to be expended and about which feeling was released, there was no meaning. The significance of objectivism may be disputed, but if a poem is worthy of attention, there is a conveyance of "meaning/perception/feeling" by an act of creation.

For the doctor, the convention holds that the products of thought are an assessment of health and sickness, and from that in turn a plan of management or care. The subject-object of the exercise is a person, whose health cannot be thought about without awareness of personhood. Unless the formal context of medical thought also is a vehicle for feeling and emotion about the person, it has no significance, and becomes, not a shell, but a prison within which the patient is restrained. Indeed, successful evaluation of the medical thought requires understanding of the person who is being thought about. Most medical care, and in primary medicine, the ovewhelming bulk of care, is given by patients of families to themselves. What the doctor provides is advice, founded on the understanding of that person, and thought out by the requirements of medical logic. Such advice is meaningless unless rooted in personal understanding.

I would contend that there are similarities in the production of poets and doctors. The poem, to the extent that it is constructed as Ciardi's "formal context" is rational-logical as well as intuitive-creative, and the plan of medical management, to the extent that it recognizes the person as well as the disease, must be creative as well as logical. In this fashion, it appears to me, there occurs the fusion of the sensibility of medicine and humanism, whose disparity is discussed by Professor Joanne Trautmann later in this article.

There has been a tendency to assume that these diverge, and that the values of the artist, of beauty, of caring, and of necessity are separate from the logic and coldness of medicine. If the physician must objectify in order to think, but know the person in order to be effective, then there may be a contrast, or duality of some sort. But when the physician is able to infuse the thought structure with affective content, that duality fuses into an entity. Perhaps Williams has shown us one example of how this is done.

The accomplishment of Williams the doctor was measured by the patients for whom he gave care and love. The accomplishment of Williams the poet is measured by his peers. The accomplishment of Williams the doctor and poet, the poet and doctor, may be a fusion of the sensibility of medicine and of humanism.

To illustrate how Williams the doctor went about his work, a number of anecdotes by a former patient are of value. Helen Williamson Fall, a resident of Rutherford, was a patient of Williams. In 1977, as part of an oral history project, she was interviewed by James Edward Fall, her son.*

Mrs. Fall's description of her relationship with the doctor is as follows:

"The overall impression is, this was a man I loved. I loved him for his sweetness. I loved him because he made me feel special to him. I loved him because I thought he was my ally —I know he was my ally, in a situation that, he appreciated, could be difficult—and boy, do you ever, ever have a warm spot in your heart for that ray of sunshine in what looked like a very bleak area."

There were reasons for the closeness of their relationship. Williams could combine medical thinking of the day, and an awareness of the person. One of Mrs. Fall's children swallowed medicine for worming a dog. She called her doctor.

"I immediately called up Dr. Williams and said, 'I'm not certain, but I know Fred has swallowed one dog worm capsule. It could be two.'

"And he said, 'How did your dog behave?'

"I said, 'Well, the dog acted drunk, and then had bowel movements, but he acted like he was drunk after he'd had them down a while.'

"He said, 'Well, watch Fred, and as he's going to do the same thing, as soon as he starts reeling around, put him in his crib.' So it was a Sunday. I thanked him very much, and sure enough, Fred started to reel around, so I put him in his crib and he was—well, there he was.

"The doorbell rang. I wasn't expecting anyone. I ran to the door and it was Dr. Williams. He said, 'You know, I just had to come over and see. I had to see. I gave him about half an hour and I figured, I'm going to go over and see that kid, how he is with the two worm capsules.'

"Well, sure enough, there was Freddie, hanging, with the bars of the side of the crib under each arm, and a hand hanging down and a head lolling, and the foolish grin, and Dr. Williams went up and hugged him and he said, 'You've got the cheapest drunk I've ever seen.'

"So we talked a little bit and I thanked him for coming. He said, 'Don't thank me, I was curious.'

"But that was, again, that human element of having time for people. He was just so curious, he just had to see, what was this child going to do? He was a dear man. I've always loved that about him. He was interested."

The doctor and the patient were allies. Their relationship used the strengths of both for health care. On one occasion Mrs. Fall's mother-in-law had insisted that a child be given mashed bananas with all the seeds scraped out, resulting in a great deal of work. Mrs. Fall resolved to obtain help:

"I think I made a point of having him come to the house, because naturally she didn't go with me when I went to the office for checkups and things . . . we were sitting in the living room, the three of us . . . and I said to him, 'Dr. Williams, do I have to take the seeds out of the mashed bananas?' And his eyebrows shot up a mile high and he said, 'What?' I said, 'The seeds. I've been splitting the bananas, so that I could scrape away all those little black things.' Well, he

*Grateful acknowledgment is given to James Edward Fall for the use of his oral history project.

aughed. He said, 'Where did you get that idea?' I said, 'Well, I just heard that they were what caused trouble.' And he said, You take the skin off that banana, put it in a dish, mash it with a fork, and shove it down the baby.' He knew where I had heard it. But I never had to say. And from then on, I was left alone."

On another occasion, during World War II, Mrs. Fall was living with her in-laws under crowded circumstances.

"Well, I wanted my own home again . . . and I saw this delightful and very easy way to move out and have my own home again—if I got pregnant also—because that household wasn't quite set up to handle all of us. So I planned to have a baby, which I did. I wanted the family to think I was very distressed at this turn of events—quite by accident, oh, a terrible thing. So, in order to make (them) feel more kindly about our moving out, I went down to see Dr. Williams in his office one afternoon and I said to him, 'I believe I'm pregnant. I want to move out without a great big hassle about our leaving that household. So, I am going to call you up, when (my mother-in-law) is within hearing, and I'm going to ask you for something to bring my period on, but actually what I want is a tonic. I want a blood builder of some sort. But as far as you know, I'm calling you for a prescription to bring me around, but you'll know what you're going to send me.'

"So this is what I did. I made a point of saying, 'Doctor, I think I'm pregnant. I may not be, but I think I am. Can you send me something that possibly could bring me around?' And when the medicine came, it was iron, but was a tonic—which is what he did for me, because I had explained to him that this was an opportunity to have my own home. But I couldn't have done that with any other doctor but Dr. Williams, because he understood the whole situation and how difficult it was, and why I would be an opportunist. So he was more than willing to be helpful."

Mrs. Fall recounts several other anecdotes about Dr. Williams, of a nature less personal to her, but equally illuminating to the man and how he conducted his life:

"He was the kindest of people, to somebody in trouble. I had some little stories—I heard them, he told them to me—which showed his warmth and how he felt. He was not, as a doctor, supposed to do any of these things, but he told me, he definitely believed suffering should be eliminated, if it's possible, and he told me of a family in the town who had a loved one in torment, dying of cancer, with no hope of recovery, and they begged him, 'Put him out of his misery.' I'm saying 'him.' I've forgotten whether it was put him out or put her out.

"And he accommodated them, and with the most rueful, sad smile he added, 'And do you know, I never set foot inside that house again. They never called me. They acted as though I didn't exist.' Which was sad, because he had done something against the law, but right within his own life, at the pleading of the family. Once he had done it, he had become a pariah. This saddened him, not for what happened to him, but for those people.

"You know, he was a darling man, and had the kindest and sweetest way with people. When I read his biography, his autobiography, he rather surprised me. In fact, when I read his novels he surprised me, but more so—he had a great warmth for people. He loved people. He really did. What he didn't suffer gladly was hypocrisy and fools. He didn't suffer fools gladly, and he didn't like hypocrisy, and he saw such a veneer of hypocrisy in this town. When he belabored his townspeople, and he did, it was mainly because he loved them. They, of course, took great exception to this. But I have to say, when he dealt with you, his smile was one of the sweetest, warmest—sweet smile is the only way I can express it. He often would tell me what he had done, and said it just casually, not to praise himself in any way. He'd say. 'I was out at 5:30 this morning. Got a call from an elderly patient. She was without heat. Her furnace fire had gone out.' And it was just a matter of course; he built her furnace fire before he left her house. To speak about building a furnace fire nowadays, most people have never built one. They don't know what a time-consuming thing that was. But he just took for granted that, as a doctor, giving her a furnace fire was part of the way a doctor did for people. He always was this way."

"The accomplishment of Williams the doctor was measured by the patients for whom he gave care and love."

Professor Joanne Trautmann, of the Department of Humanities of Pennsylvania State University, indicated, in an article published several years ago, how Williams fused the sensibility of the humanist and the physician. I am indebted to Professor Trautmann and Pergamon Press for permission to reproduce three sections of a longer article dealing with Dr. Williams's literary theories of objectivity. The sections quoted here are buttressed in the original with reference to modern aesthetic theory:

In spite of the recent attempt in America to educate a new kind of health professional, knowledgeable in the social sciences and alive to the humanistic disciplines, I have noticed, in the conversations and classes of medical humanists, a tendency to assume a clear distinction between the humanistic sensibility and the medical sensibility. The humanistic sensibility is assumed to be subjectively-oriented, self-conscious, caring, imaginative, in pursuit of emotions and beauty as well as truth—in short, "sensitive." The medical sensibility is assumed to be objective, self-effacing, circumscribed, interested in the rational and factual rather than in nuances—in short, "cold."

Humanists in a health education setting are committed to easing this fragmentation. For the most part, I think, we are content to bring the humanistic sensibility into the health context and to urge that some elements of that sensibility be taken on by people who have essentially a different perspective on life. We speak hopefully of the "value-oriented physician," and we mean by that a person who is basically a medical scientist in outlook but who has some of the important attributes of the concerned, informed humanist. We know that this state is a difficult one to achieve and even more difficult to maintain. Sometimes the demands of the two sensibilities seem to pull our students apart.

We can help them by pointing to models, people who have elements of sensibilities in their lifestyles. In literature, for instance, one can point to Anton Chekhov. But his famous line, "Medicine is my lawful wife; literature is my mistress," may not, finally, be much help, for the line reveals that his two interests were separate. We know that a wife and a mistress should seldom meet. Furthermore, the line makes literature seem glamorous, and medicine, where our students must spend most of their hours, seem a practical, day-to-day

existence which makes a mistress necessary. In this paper I want to examine the sensibilities of a second model, William Carlos Williams, who was for most of his adult life both physician and poet, and a revered practitioner in each sphere.

The external data of his life are simple, and so widely known that they need only be outlined here. He was born in 1883 in the small northern New Jersey town of Rutherford, and died there 80 years later. He studied medicine at the University of Pennsylvania, then took two internships in New York City—one in general medicine, the other in pediatrics—and afterwards travelled to Europe. In 1910, he returned to Rutherford to spend 40 years caring for its inhabitants. He was a doctor for their illnesses and a poet for their health. Over the years he wrote regularly—poems, fiction, plays, essays—but he achieved literary status chiefly for his poetry, that relatively objective celebration of the actual which culminated in the ambitious epic, *Paterson*. Though he became a famous poet, and esteemed, someone who might be expected, therefore, to devote all his time to writing, Dr. Williams did not at any time consider giving up his practice until 1951, when a series of strokes forced him to retire from half his professional life.

It would be inaccurate to think of Williams as leading two separate lives. He was not, in some melodramatic fashion, by day an ordinary physician in Rutherford, New Jersey, and by night a major American poet, the intellectual intimate of Wallace Stevens and Ezra Pound. It is true that his patients kept him from writing much during the day—though he used to pull out a typewriter and dash down a short poem between appointments—but he did not switch to his other self at night. Instead he seems to have achieved, with some struggle. I might add, a merged sensibility. In him we cannot easily discern separate medical and humanistic sensibilities. He writes in his *Autobiography* that for him medicine and poetry were nearly the same thing. Now that is a difficult concept to understand. If it is true, it is a magical, almost miraculous, phenomenon. And perhaps only Williams knows precisely what he means. But we can at least attempt to understand him. To the extent that we do understand, we can offer him as a model for our new health professional.

In "The Artist," Williams has left us an image of what the artist accomplishes. The poem runs:

Mr. T
bareheaded
in a soiled undershirt
his hair standing out
on all sides
stood on his toes
heels together
arms gracefully
for the moment
curled above his head.
Then he whirled about
bounded
into the air
and with an *entrechat*
perfectly achieved
completed the figure.
My mother
taken by surprise
where she sat
in her invalid's chair
was left speechless.
Bravo! she cried at last
and clapped her hands.
The man's wife
came from the kitchen:
What goes on here? she said.
But the show was over.

In this delightful capturing of the artistic moment, it is easy enough to see that the envisioned creator is akin to Williams's ideal of the doctor. Mr. T, the artist, representative in this case of all true and proper artists, is, in the first place, bareheaded. So, in a sense, is Williams whenever he stands in contemplation of the world. Comparing himself to Ezra Pound, whom he sees as a posturer of the most pompous and ridiculous sort, Williams says of himself as poet: "My upbringing assumed rather the humility and caution of the scientist." He stands bareheaded before life.

The artist of Williams's poem is more than humble; he is soiled and unkempt as well. Dr. Williams too was soiled and unkempt. He practiced all his life among the neglected and just plain frumpy. He immersed himself in the local, reasoning that the international and sophisticated, though it attracted him passionately for a time, were not as vital a source of poetry as one's native ground, however uncultivated. Williams's conception of a real artist was Walt Whitman, a man who was true to his native environment and who was, as it happens, often seen in a soiled shirt with his hair standing out on all sides. The artist, in short, is someone who accepts his ordinariness and the ordinariness of life. More than that, he accepts the dirt, the soil. Williams has written elsewhere, in a poem called "The Wanderer," a vision of a young man who immerses himself in soil in the form of "the Passaic, that filthy river" until he feels "the utter depth of its rottenness/the vile breadth of its degradation." In this way does Williams the doctor accept the ugliness he sees every day; that same ugliness is essential to Williams the artist, for it is not through beauty alone that art comes.

Going back to the poem, we see that Mr. T, soiled and unkempt though he may be, is also capable of using his body for the purpose of elegant insight. As a physician Williams is, quite naturally, fascinated by the body. But as this poem begins to show us, he is more than fascinated. He seems to feel that the body has a way of talking to us. In one of his essays Williams speaks of the body as a source of artistic insights. He is talking about why poets, and by extension, all artists, are often considered to be unbalanced creatures. It is because they do, in a sense, hear voices, but the voices come from our true selves, from our bodies: "It is the deeper, not 'lower' (in the usually silly sense) portions of the personality speaking, the middle brain, the nerves, the glands, the very muscles and bones of the body itself speaking." Mr. T, in using his body to dance, has fused the physical and the artistic into a perfectly achieved and complete figure, much as Williams does when he creates. The ordinary Mr. T has created something quite extraordinary.

The true artist, in Williams's world, is, like the physician, someone who cares for other people, someone who actively does something for others. In this poem the comparison I have drawn between the physician and the artist becomes explicit when one notices that the audience for this artist's, Mr. T's, work is an invalid, a kind of patient. Mr. T doesn't get her out of her wheelchair—Dr. Williams writes in his *Autobiography* that he has lived with illness too long to believe in "cures"—but he does bring her something momentarily wonderful. She is surprised, she is left speechless. At

ast she cries "Bravo!" and claps her hands, a physical response to a physical gesture.

The invalid has been startled into a vital response by a single, extraordinary, and perfect artistic act. And if we read the poem attentively, we too are startled from our perhaps invalid state by the total poem itself. But only momentarily. By the end of the poem, the dance has stopped, the show is over. We have heard the body speaking, but now the show is over. Mundane life has reasserted itself in the form of the wife coming from the kitchen. But we remember that the startling moment arose originally from something quite mundane, and that gives us hope.

In the poem Williams has presented us with a view of the artist as a kind of physician, a physician of the Williams sort at least. With some speculation and a little help from the *Autobiography,* we can turn the situation around and ask, what kind of physician would a man like Williams be? We have seen the artist as doctor. What of the doctor as artist?

If Williams had had an ordinary sensibility, he would have found the practice of medicine a zestless affair. Writing, the humanistic-artistic part of his sensibility, was for him absolutely essential so that he might be relieved of the boredom, as he saw it, of medicine pure and simple. Williams believed that "to treat a man as something to which surgery, drugs, and hoodoo applied was an indifferent matter; to treat him as material for a work of art made him somehow come alive to me." Williams the physician, then, sought among his patients for material which might find its way into poem, story, play, or novel.

That brings up the question of professional distance between the doctor and his patient. Williams was not the indifferent mechanic of the body so feared by patients. Clearly he was not like a sentimental hospital volunteer either. With his fused sensibility he was somewhere, perhaps everywhere, in between. He has written that his patients intrigued him mightily, yet as an artist he could not normally afford to get so close to them that his vision was blurred.

I have said "normally" he could not. But there was a way in which he got close to them without becoming, as wise medical educators warn their students, too involved to operate rationally. As an artist-physician, he apparently developed a method whereby he could for the moment merge his mind with that of the patient, becoming them for a time. He was, as he puts it in his *Autobiography,* watching the patient's mind as it watched him. He was close, he understood, he cared intensely; but for all that, his artist's mind had control of the entire situation, enabling him to react professionally, to make diagnoses and to treat the patient.

While the doctor Williams watched the disease, the artist Williams watched the person with the disease. And somehow it was all wrapped up together. The doctor needed the artist to make proper diagnoses; and the artist needed the doctor to gain him admission into the great intimacies of ordinary life which are the stuff of art. In the births, illnesses, recoveries, and deaths of his patients, Williams was seeking something which he has trouble defining. He speaks of it, in fact, as the "thing." The "thing," he says, appears in his daily practice in the eyes of his patients. It brushes past him, disturbing one of his five senses: "There the thing was, right in front of me. I could touch it, smell it . . . Oh, I knew it wasn't for the most part giving me anything very profound, but it was giving me the terms, basic terms with which I could spell out matters as profound as I cared to think about." Finally he can name the "thing": "It is our very life. It is we ourselves, at our rarest moments." This, then, was the enormous value behind Williams's practice of medicine and why for 42 years he never thought of giving up medicine to do nothing but write. Without this he would not have had the entrée into what he calls "the great sights that I see every day." He would not have had his closeness to the body, from which his art sprang.

In spite of all that I have said, for some humanistically-inclined medical people Williams will seem an unlikely model. Far from seeing his objectivity and his wise contact as an enviable kind of sensibility, they may distrust a man who sees his patients as material for art. I myself feel admiration, as opposed to real affection, for the man. But finally, I think, he defines a new kind of warmth, for certainly he is responsibly involved with his patients.

Few of our students and physicians can be William Carlos Williamses. Perhaps not many can even come close to achieving his particular kind of fused sensibility. Nonetheless, he is useful as a model for several reasons. In the first place, even a superficial knowledge of his life and work makes us realize that the humanistic sensibility need not be so opposed to the medical. Furthermore, he shows us that the two can be fused in ways that might not be immediately apparent, to humanists at least. When I first came into the medical setting, former colleagues from my deserted ivory tower thought I was going into the wilderness to bring some sense of human values to the medical mind. No doubt I thought so too. I confess that I had not adequately realized until I started to reread Williams in a medical school environment that the medical sensibility had a good deal to offer the artist and a good deal to teach the person interested in human values. Williams shows all of us that we need not necessarily fear the physician's distance from his patient. After all, that distance might be, as in Williams' case, a new kind of humanistic objectivity.

This should be particularly welcome news for medical students. I have watched some of my most sensitive students on the verge of cracking up over what they see as a split in their characters. (It seems to them to occur about midway through the second year.) They come in as idealistic first-year students, vowing to the admissions committee that they will treat the whole person, that they will never lose sight of the psychological and cultural aspects of their patients. And then, before they even begin their clinical study, they find themselves bogged down in so many technical details that the big questions go unanswered, even unasked. Williams can show them that, after the initial years of study, at least, it is possible to integrate, that it is possible to see the most extraordinary sights in the most ordinary of details, that the study of the body, far from taking them away from their most important cares, can bring them closer to the mysteries of life in a philosophical sense, that their experiences with the intricacies of health and disease can open up the wisdom of their senses in ways they have not yet dreamed of.

Not many of our physicians will choose to be writers—though there seems to be a natural affinity between the health professions and writing—but all of them can share in the basic response to life of a man like Williams. They need not actually write or paint or compose to share the artist's need to perceive ever more distinctly and understand ever more fully. They see the essence of human life, in its scientific and its humanistic aspects, every day of their working lives. All they need is the training to see it clearly and wisely.* ■

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ma baby. You know, the one I talked
to you about last night.

What was that?

Is this the baby specialist?

Yes, but perhaps you mean my son,
can't you wait until . ?

I, I, I don't think it's brEAthin'

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ORIGINAL ARTICLE

William Carlos Williams: His Art

JAMES GUIMOND, Ph.D.*

At a conference at the University of Pennsylvania a few years ago, the critic Hugh Kenner analyzed how Ezra Pound—Williams's close friend and fellow Penn alumnus—might have been influenced by the undergraduate courses he took when he was a freshman at Penn. Williams, who entered the medical school in 1902 by passing a special examination, never had a bachelor's degree, and he never took any undergraduate courses. Someone asked Kenner to speculate about the effect that an undergraduate education would have had on Williams. "It probably would have ruined him," Kenner replied, and he may have been right.

For Williams's generation, as well as later ones, an American undergraduate education was a process of what sociologists politely call socialization as well as education—an opportunity to learn the attitudes, the manners, and the mores (as well as some of the ideas and skills) that one needs to be accepted as a middle- or upper-middle-class American. By going directly from his secondary education at Horace Mann School directly into Penn's medical school, Williams "vaulted" into a middle-class profession and society, and for the rest of his life he had a rather ambivalent relationship to the middle-class world in which he was a writer and a physician.

Unlike Pound, who graduated from Hamilton in 1905, received his Master of Arts degree from Penn in 1906, and then lived most of his life in Europe and spent 13 years interned in St. Elizabeth's because of his fascist beliefs during World War II, Williams never totally rejected American social and political values. Nor did he ever become a conservative like Wallace Stevens, who spent 3 years as a special student at Harvard, graduated from the New York Law School in 1903, and then became a fine poet while enjoying a successful but colorless career as a Vice-President of the Hartford Insurance Company. Instead Williams occupied a complicated position between these two extremes—accepting some things in American life and rejecting others so that his life was an ambiguous pattern of conformities, compromises, affirmations, successes, and failures.

Reed Whittemore, Williams's first biographer, wrote that both of Williams's sons agreed that their father was a "loner," who was not "close" to other doctors in the community. "He called the rich ones society doctors and 'top brass' and he was proud that he was not like them, but he wasn't close to the doctors he liked either."[1] However, even though he might not have been friendly with doctors, Williams and his wife, Flossie, had other friends in Rutherford. They were charter members and leaders of a very middle-class social club, the Polytopics, whose members wore tuxedoes and evening dresses and entertained themselves with skits, games, and lectures. He was respected enough in his local medical community to become President of the Board of Directors of the Passaic General Hospital, and he received the kinds of honors which cities like Rutherford reserve for their distinguished citizens. In 1951, for example, when he published his *Autobiography*, his friends and the Rutherford Chamber of Commerce gave a party for him at the Elks Club on his 68th birthday.[2]

As a writer, Williams was never very popular or a "bestseller." He had a great deal of difficulty finding publishers for some of his books of poems, which sold very poorly; and as late as the 1940s when he was in his 60s, two of his books, *The Wedge* and *The Clouds*, were published by a tiny press in the Berkshires in editions of 380 and 310 copies. Many reviewers and periodicals ignored his writings, particularly during the 1930s, and sometimes Williams could be painfully insecure and defensive when he gave readings or lectures to literary and academic audiences. Yet, he was a popular member of the avant-garde culture which flourished in Greenwich Village in the 1920s, he carried on a spirited,

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love-hate friendship with Pound for decades, and eventually he received some very prestigious literary awards—the Dial Award in 1926, the National Book Award for poetry in 1950, and the Bollingen Award in 1953. Finally, near the end of his life he also was extremely pleased by the respect and admiration he received from younger poets like Robert Lowell, Allen Ginsberg, and Denise Levertov.

Some of the same ambiguities existed in the relationship between Williams's career as a writer and his medical practice. In public, writing in his *Autobiography*, he eloquently idealized this relationship—particularly in chapter 54—where he claimed that there were never any conflicts between his two careers and that his medical practice was a great inspiration for his writing: "As a writer I have never felt that medicine interfered with me but rather that it was . . . the very thing which made it possible for me to write. . . . As far as the writing itself is concerned it takes next to no time at all . . . there is always time to bang out a few pages."[3] More privately, Williams complained in letters to his friends that his medical responsibilities never left him the precious time which he needed to do what he really wanted to do, which—in his case—was to write.[2] In fact, Williams's two careers enriched and cross-fertilized each other, but they did so on several different levels and in a variety of ways which are expressed in his writings.

Williams portrays himself in some of his short stories as a tough-minded but tender-hearted doctor who cared about his patients as people as well as cases. Williams's implicit presence as a writer in these stories essentially is similar to his more explicit portrayal of himself as a doctor. Both Williamses are, a little self-consciously, "tough-guys" who like to shock their audiences a bit and then reassure them that they are sympathetic after all.[4] In "Jean Beicke," for example, he describes himself joking with the nurses as he does his rounds in a ward full of sick children during the Depression: "I often kid the girls. Why not? I look at some miserable specimens they've dolled up for me . . . and I tell them: Give it an enema, maybe it will get well and grow up into a cheap prostitute or something."[5]

But in the next paragraph he immediately exclaims, "Poor kids! You really wonder if medicine isn't all wrong to try to do anything for them at all."[5] Williams the tough-minded, middle-class professional man has no sentimental illusions about the children's probable fates, yet he also is pained by this realization. Williams-the-writer equally is tough-minded in this story. He describes the grim death of the baby whose name gives the story its title: she dies because he and the other doctors fail to make a correct diagnosis. There are no *Saturday Evening Post* or MGM happy endings for him, yet he also is sensitive enough to describe his own feelings and to emphasize the grief of the nurse who refuses to see the autopsy—"I couldn't get the nurse to go down to it. I may be a sap, she said, but I can't do it, that's all. I can't. Not when I've taken care of them. . . ."[5]

In a number of other stories, "A Night in June," "A Face of Stone," "The Girl with the Pimply Face," and "Ancient Gentility," Williams's presence in the story as a doctor is less significant, because he presents his patients-subjects as being intrinsically more interesting than he is. True, these stories may start out with Williams-the-doctor making a house call or a diagnosis, but in the course of them he quickly becomes a kind of medical straight man (like the interviewer in a good documentary) whose services to his patients are pretexts for Williams-the-writer to tell us more about their lives. The people in these stories are mostly ethnics—Jewish, Russian or Italian emigrants and their children who definitely were not part of mainstream America; and Williams presents himself as a kind of middle-class suburban Columbus who is surprised and excited by the new worlds he keeps discovering behind his patients' doors and garden fences.

In "Ancient Gentility," in particular, the whole story is devoted to his discovery and appreciation of how an old Italian couple live in their tiny box of a house on Guinea Hill. He goes to the house because a neighbor asks him "to visit the old people next door," because the "old lady's sick." The neighbor hints that the old people won't be able to pay Williams for the visit, but she hopes that he will do it anyway ("I'll fix it up with you sometime. Will you do it—for me?"). Williams is delighted at the opportunity, the old woman is not very sick, and the rest of the story consists of his descriptions of the old people and the way in which they have managed to transport their way of life virtually intact from Calabria to northern New Jersey within sight of Manhattan. For example, their tiny house has only two rooms, and the ground floor was "just one room, everything combined: you cooked in one corner, ate close by, and sat yourself down to talk with your friends and relatives over beyond. Everything was immaculately clean and smelt just tinged with that faint odor of garlic, peppers, and olive oil which one gets to expect in all these peasant houses."[5]

What is interesting in these stories is the delicate balance that exists between the familiar and the unfamiliar. The contents of these stories may have been unfamiliar to Williams's middle-class readers both when they were published and more recently—most of us never have had the opportunity to visit one of "these peasant houses" or had to put our children into the kind of hospital ward where Jean Beicke died—but the roles in which Williams portrays himself are not so unfamiliar. The tough guy with a heart is a familiar character in middle-class professional life: lawyers, professors, social workers, and executives (as well as doctors) often "kid" and behave in the way Williams does in "Jean Beicke." As for the stories in which he is primarily an observer rather than a participant, one of the conventions of our popular culture—movies and television as well as books—is that professional people, like doctors, along with policemen and lawyers, often are narrators because it seems to be taken for granted that they have a special access into other people's lives. Williams's stories of this type are far more concise and sensitive than the ones which appear on the screen or in popular fiction, but Williams spoke of himself in his *Autobiography* as if it was his profession, more than his own sensitivity, which had given him this kind of special access. "My 'medicine' was the thing which gained me entrance to these secret gardens of the self," he claimed. "It lay there, another world, in the self. I was permitted by my medical badge to follow the poor, defeated body into those gulfs and grottos."

But there were also "secret gardens" in Williams and in a few of what I would consider his very best works, he suddenly breaks—or is surprised—out of his roles as a middle-class doctor and writer and reveals darker and more disturbing aspects of his personality. In his story "The Use of Force," Williams gave a merciless description of his feelings when he had to try to examine the throat of an angry, frightened child who had diphtheria. Though he did not mention her age, Williams described the child as being very pretty in a stereotyped way. At first Williams-the-doctor

sponded to the child and the situation in an equally ereotyped way. He questioned the parents politely about er symptoms, smiled in what he called "his best professional anner," and asked to see her throat. But the child was no hirley Temple, she attacked Williams, knocked his glasses ying, and furiously resisted his efforts to open her mouth. nd Williams, equally furious, quickly stopped being nice ld Doc Williams, the tough-minded but tender-hearted aby doctor. Instead of examining the child, he has begun to buse her, and—what is more disturbing—this abuse has a istinctly sexual element in it. The flustered, frightened arents cannot know this as they watch the doctor struggle ith their child, but Williams knows it and says it—in the ory. At the end, he does get the child's mouth open to iscover that she does have diphtheria. Therefore, medically, e may have been right to continue the diagnosis. But by this tage of the story, this rational information has become lmost irrelevant because of what Williams has revealed bout himself. The child's sore throat, he said, was "her ecret"; and now Williams-the-writer also has gone "on to he end" to reveal the irrational brutality and sexuality which vas his "secret," even to himself.

His poem, "To Elsie," which he wrote in the early 1920s, s another work in which diagnosis is transformed into self-evelation. Elsie was one of a series of "state wards" who ived with the Williams family—girls who were orphans or ad to be removed from their families and hired out as ervants. She was, he said in the poem, a "girl so desolate/so emmed round/with disease or murder" that she had been 'rescued by an/agent—/reared by the state," then "sent out t fifteen to work in/some hard-pressed/house in the sub-rbs—/some doctor's family,"* which was clearly his own. From what Williams said in the poem and in his *Autobiography,* it seems that Elsie was more pathetic than the other wards and that her desolation had expressed itself sexually. In one chapter in the *Autobiography,* he said he could remember a "terrible landscape one summer . . . in Vermont" when "the half-wit Elsie" had accompanied them on vacation and had gone bathing in a small stream by a field where some men, who were haying, could see her and had started to watch her. Two chapters earlier, he had made some other comments about the "state wards" which probably also referred to Elsie, though he did not name her.

Williams is not explicitly present in this poem as a doctor, as he is in his stories. However, the first half of the poem contains a good deal of implicit diagnosis of Elsie, who is, he implies at the beginning of the poem, one of

> The pure products of America [who]
> go crazy—
> mountain folk from Kentucky
>
> or the ribbed north end of
> Jersey
> with its isolate lakes and
>
> valleys, its deaf-mutes, thieves
> old names
> and promiscuity . . .

In the 1920s, as well as in later decades, middle-class Americans were very interested in theories which explained (to their satisfaction) the behavior of their fellow citizens who were poorer than they were. In the 1920s, there was a particular emphasis on rural poverty, and many of these theories tried to explain why so many rural Americans seemed trapped, generation after generation, in vicious cycles of ignorance, crime, poverty, and disease. It was the heyday of the controversy over nature versus nurture and theories like those of eugenics movement that claimed many poor Americans were mostly rural degenerates, like the Kallikaks,

"Williams-the-writer did something which was more disturbing and also impressive—to lay himself bare before us in terms which he could not escape."

who were genetic threats to the nation's virtue and therefore needed to be segregated or sterilized.[6] Of course, we cannot know what Williams thought of these theories from his poem, but as a doctor he must have been aware of them. Trying to deal with Elsie, he must have at least considered the various more or less "scientific" ideas which were being used to explain why "the pure products of America/go crazy"—and had these ideas in the back of his mind when he said in the poem that these "pure products" had "old names" and were from places like Kentucky and the isolated parts of north Jersey.

But what is more important, in the first half of the poem he speaks from the position of the medical or social scientist who instinctively assumes that we—the educated people in our society—can speak of and understand them—the "deaf-mutes, thieves . . . devil-may-care men," and "young slatterns" like Elsie. But at the midpoint of the poem, just as we expect Williams to go on and complete his diagnosis of what is wrong with Elsie and what her fate will be, his viewpoint changes suddenly and radically. Elsie, he says, expresses "with broken/brain the truth about us—." He equates her pathetic desire for finery and love, "cheap/jewelry/and rich young men with fine eyes," with the vague desire for—love? beauty? nature?—whatever it is that often makes even American poets and doctors so dissatisfied with their/our lives:

> as if the earth under our feet
> were
> an excrement of some sky
>
> and we degraded prisoners
> destined
> to hunger until we eat filth
>
> while the imagination strains
> after deer
> going by fields of goldenrod . . .

It is not so much a relentless revelation, like that which occurs in "The Use of Force," but a kind of sudden transformation which happens in "To Elsie"—a transformation which is expressed verbally by his unexpected switch from the third to the first person plural as the subject of the poem becomes "us" rather than "she" and "Elsie." Nevertheless, the effect is the same: diagnosis has become confession, entering the "secret gardens" of others' selves has

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become Williams's way of discovering and revealing his own secrets.

So on one level Williams probably was right about his medical career and its beneficial effect on his writing. As he claimed in his *Autobiography,* perhaps a little too eloquently, the medical diagnoses which he made could lead directly to another kind of diagnosis which he could use as a writer. "My business, aside from the mere physical diagnosis, is to make a different sort of diagnosis concerning them as individuals," he said, speaking of himself as both a doctor and writer, "that fascinates me. From the very beginning that fascinated me even more than I knew . . . . And when one is able to reveal them [people] to themselves . . . they are always grateful as they are surprised that one can so have revealed the inner secrets of another's private motives. To do this is what makes a writer worth heeding; that somehow or other, whatever the source may be, he has gone to the base of the matter to lay it bare before us in terms which, try as we may, we cannot in the end escape. There is no choice then but to accept him and make him a hero."[3]

Everyone wants to be a hero, and Williams was no exception. So perhaps that is why he portrayed himself so favorably in his *Autobiography* as being, among other things, an almost exemplary poet-doctor who helped people with his writing in much the same way that he helped them with his medicine. But in some of his other works, like "The Use of Force" and "To Elsie," Williams-the-writer did something which was more disturbing and also more impressive—which was to lay himself "bare before us in terms" which he could not escape. What he said about himself in those works was not "heroic" in any conventional sense, and it must have taken an unconventional kind of heroism—or honesty—to say it. ■

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each other diagonally downward

across the canvas
from one side
to stumble finally into a bog

where the picture
and the composition ends back
of which no seeing man

is represented the unshaven
features of the des-
titute with their few

pitiful possessions a basin
to wash in a peasant
cottage is seen and a church spire

the faces are raised
as toward the light
there is no detail extraneous

to the composition one
follows the others stick in
hand triumphant to disaster

*Grateful acknowledgment is given to New Directions Publishing Corp. for permission to reprint "The Parable of the Blind" from *Pictures from Brueghel and Other Poems* (copyright ©1949, 1951, 1952, 1953, 1954, 1962 by William Carlos Williams).



Figure—*The Parable of the Blind.* Peter Brueghel. Grateful acknowledgment is given to Soprintendenza per i Beni Artistici e Storici di Napoli for permission to reprint this painting from Napoli, Museo e Gallerie Nazionali di Capodimonte.

ORIGINAL ARTICLE

The Medical Nature of William Carlos Williams

ANDREW GIARELLI*

One poet reviewing the biography of William Carlos Williams by Paul Mariani writes that Williams could have quit doctoring earlier if he'd gotten the recognition he deserved earlier. That says more about the occasional arrogance of poetry than it does about Dr. Williams, whose doctoring and writing were parasitical to one another—but only in the best sense. Medicine was the mother-lode for half his writing ventures. For Williams, medicine was at first "a duty, a monotonous duty, which he performed perfunctorily in order to get on with the real business of life, which was art," writes Mariani. The devotion of the 25- and even the 30-year-old Williams to his big, dreamy entity called art was obvious and often silly.

However, in September, 1910, many people in Rutherford probably had trouble reconciling the young pediatrician who started a practice and became the school physician with "Willie the poet," as locals then called him. Few of those contemporaries remain in Rutherford today, but Williams himself has documented his early unease with medicine, equating it with petty prejudice and provinciality and his own perceived shortcomings: "I do not always get on well in this town. . . . I especially cannot compete with other doctors. I refuse to join church, Elks, Royal Arcanum club, Masons. . . . I do not see the sense of operating on people myself when they can get a better man to do it cheaper in New York. . . . I find a doctor in this community to have a special function. He is primarily an outpost. I am interested in babies because their processes are not yet affected by calcification and because diagnosis rests almost wholly upon a perception of the objective signs."

Despite any misgivings he might have revealed to the literary world or kept to himself, Williams scrupulously performed the social duties associated with the new doctor in town. In 1916, he helped found a cultural discussion group called the Polytopics Club after being denied membership in a similar established group, the Fortnightly Club. "Here they are meeting ten minutes from New York City in full dress," laughs Rutherford Public Library director Gladys Eckardt, a friend of Williams during the last decade of his life and now guardian of the town's William Carlos Williams room. "The accent was on culture, with a capital C." She says that in a self-effacing way, as if both amused and embarrassed by Rutherford's hunger for the sort of idealized culture that young Dr. Williams, too, carried within himself. The Polytopics Club, by the way, still meets in Rutherford.

The town where the young doctor mixed feelings about medicine and patients is isolated. The Jersey Meadows below the eastern edge of Rutherford was "a complete jungle," says Fairleigh Dickinson English professor John Dollar. Looming over the "jungle" were Manhattan's young skyscrapers, almost too close for comfort. Nearer the Passaic River, "Kipp's Woods" spread over what is now the Fairleigh Dickinson campus. Just upriver and always within smelling distance were Passaic and Paterson, which was the nation's 15th largest city at the turn of the century. Yet Eleanora Monahan, who moved out from the Bronx in 1939, remembers phoning her mother in New York almost daily and crying because she saw more pigs, cows, and horses than people.

Lifelong friend, Ezra Pound called it "Ruggerford," in letters to Williams from his poet's quarters in London and Italy. A "hole in the wall," he called it upon visiting. Even today, Route 17 and its commercial sprawl do not cut into Rutherford. They avoid it, making the town seem smaller than it really is. Off Route 17, the tracks of the old Erie Railroad lead to a worn but well-kept train station and a similarly dated traffic circle, twin gateways to a slice of smalltown America. Main Street is a bit small for modern traffic demands, but drivers still wave to the traffic cops and give pedestrians the right of way. At the first big fork in the road, on the left, is Ridge Road. Ridge Road's first house,

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practically sitting atop downtown Rutherford, is the Williams house. Much to Pound's dismay, Williams lived, wrote, and practiced medicine in this mustard-yellow, slightly gingerbready affair from his marriage in 1912 to his death in 1963. The house has stayed the same color for 70 years, though one gets the feeling such constancy is not unusual for Rutherford.

"It was exclusive—all prunes and prisms," recalls Kitty Hoaglund, Williams's typist and confidante from the mid-1930s who moved here with her Irish immigrant family around 1926. The morning after moving in, her family found baskets of food on its doorstep. "That's the sort of a town it was," she says. "It always delivered everything on time." But she adds that Rutherford had a Ku Klux Klan chapter when she moved here.

"Williams was a grand person—pleasant and alert and very well-informed for a man of his many interests. And the hospital staff knew little about his writing."

The town bred an aristocracy by North Jersey standards. "You just did not walk down Main Street without a hat and gloves," says librarian Eckardt. When Williams focused on his neighbors-patients in his poetry it usually was to rip off the hats and gloves of a suburban mediocrity he found stifling. These exorcisms attacked class distinctions ("Pastoral"), corrupt sentimentalism ("Tract"), and even sexual repression ("The Lonely Street" and "The Young Housewife"). When this material started leaking out to its subjects during the 1920s—even as Dr. Williams was hosting "wild" parties of Greenwich Village artists on Ridge Road—the results could be disastrous. Eunice Brown, a Ridge Road neighbor and former society page editor of the local newspaper, remembers an early reading by Williams at her DAR meeting. "It was a scream. Oh, the ladies darn near died. They couldn't believe he would write such terrible poetry." I get the impression that Williams cherished these opportunities to upset his peers and steadiest patients. Sometimes, the Rutherford social set got in a few licks of its own. The Polytopics Club presented their minutes in the form of a typical Williams poem. The Fortnightly Club invited Williams to speak after his autobiographical novel, *A Voyage to Pagany,* was published in 1928. The novel is about a young pediatrician's European internship, and the club members were hoping for a chance to embarrass Williams with questions about the "stories of hot affairs," says Eckardt, who heard the tale from another local doctor who belonged to the Fortnightly. "They were all laying for him," she says. "But just before he was to get up and give his talk, they got a call from Flossie saying he was needed in an emergency at Passaic General." The Fortnightly Club was certain that Flossie (Mrs. Florence Williams) had concocted that emergency.

Yet, this adversary tone never soured patient-doctor relations for Williams, who by the late 1920s, was entering into a new period of recognition in both medicine and literature. Perhaps there was an anti-Williams faction in town, who would not bring their children to him because of his literary reputation (which they usually knew secondhand, at best). But by this time a strong pro-Williams faction had formed among a new generation whose faith was buttressed both by his modest new literary fame and by his appointment as codirector of pediatrics at Passiac General in 1931.

"His partner was a very dictatorial old Dutchman with a history of squeezing money out of his patients," recalls Dr. James M. Allen, at that time a young pediatrics resident at Passaic General. Dr. Allen recalls: "Williams was a grand person—pleasant and alert and very well-informed for a man of his many interests." Allen says he and other doctors at the hospital knew little about Williams's writing. "He never brought it up. You had to get him off to one side."

Williams did share his poetry with the hospital's nurses, reports former director of nursing Ann Patterson, then a student nurse, "I don't know how many of us really appreciated," she starts to say and stops in the manner of acquaintances now embarrassed to admit some ignorance concerning the man's greatness. "I mean, we just thought, 'eh, that was his pastime.' " Patterson remembers, too, an unusual degree of attention to and affection for babies. "He was extremely kind and compassionate, with the warmth you see so little of today," says Patterson.

Harold Moskowitz, a local pharmacist, said: "He was always the most friendly fellow. He was a family man. I mean, he'd always be asking about this family or that family. Believe it or not, we never knew he was so involved in poetry. He would go down the street with that bushy head of hair—never wore a hat—and he was always running. He moved very fast." Other informants remember an old straw hat, thin hair, and a slightly pigeon-toed walk, while others remember some combination of the above. Apparently several different stages in the man's physical appearance are being confused; more importantly, nearly all informants agree on quick movements, great attentiveness to minor details, and little reference to the literary life.

Williams attracted a wide range of patients—the usual Rutherford bunch, of course, but also new immigrant Italians in Lyndhurst, the Poles up around Wallington, the whole stew of races in Paterson and Passaic, and the babies of no known parentage who just appeared on the front steps of Passaic General. "Give it an enema, maybe it will get well and grow up into a cheap prostitute or something," one tired doctor orders in a Williams story from the period. One would have to read Williams's determined attentiveness to "the thing itself" in his poetry and prose of the 1930s to understand what a mixed bag of love and disgust such statements are. His sharpest proletarian portraits come from this time, as does the genesis of his five-volume epic poem *Paterson.* A twist in the medical life opened up vast new writing possibilities.

During the 1940s and early 1950s, as Williams divested himself of burdens at Passaic General and gradually turned over his local practice to his son William Eric, his relations with patients grew richer and more diverse. An example might be Eleanora Monahan, a devout Catholic whose faith through a series of crises made him idealize her as an eternal feminine figure in a poem ("For Eleanor and Bill Monahan"). Williams wrote the poem after a bloody low placental birth in which Mrs. Monahan insisted that yes, her baby would live because she was praying for it to live; he found, in this patient who named the baby after Ann, the Virgin Mary's mother, a model of strength for his own new troubles —the first of the strokes that would eventually kill him, the bouts of depression that weighed on his later years, and the

allegations of un-Americanism that sabotaged his appointment as first Poetry Consultant to the Library of Congress in 1952.

Monahan, however, remembers Williams as the model of strength. "My first impression was as if I'd always known him," she recalls. "He almost felt like my father—in fact, I used to call him father sometimes." Though Williams and his wife Flossie would visit the Monahans on Sunday afternoons, Eleanora did not know about the poem addressed to her until a later crisis. "When my youngest was three months old, she suddenly slumped over in the tub one day. I put her in a blanket and ran down to Doctor's house." His son Bill took the child, and Williams dashed upstairs to his study after calming the mother. "He came back with a volume of *Poetry* magazine with that poem in it. He said, 'Don't try to read it—just take it.' I brought it to one of the nuns at my kids' school. 'It's way out,' she said.' "

After a 1957 television interview, worried that he'd offended local friends with his comments about organized religion, Williams wrote an explanation to Eleanora Monahan. "You know that I am an unbeliever. I live by human love, male and female. You know how in detail I have all my life lived. . . . Nothing is more serious to me than to be unfaithful to a friend—but I have had to go ahead. Catholic and Jew are equal as I have faced the world, the pagan and even savages which the Church has so brutally slighted are equally sympathetic to me. But that's neither here nor there. . . . Let's keep on being friends and when we meet occasionally as we will about town let's forget it." Monahan says that she not only was not offended but that she didn't even know what Williams was talking about. "He claimed to be an atheist, which I did not believe—no atheist could feel like that."

A few close friends like Eleanora Monahan were always more accurate than most in describing their strange poet/doctor's soul. The doctor and the poet in him—the giving, attentive observer who longed to observe ever more closely—welcomed their needs. As Williams matured, so did the complex ways medicine and poetry intertwined and nourished his ability to give and to pay attention. ■

INTRODUCING
THE



TO COUNT ON

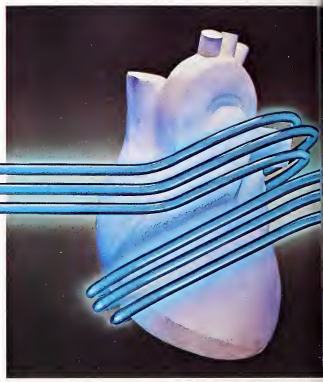
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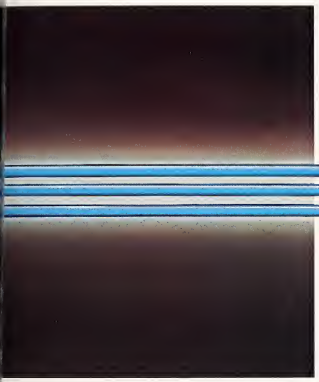
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A unique controlled-release formulation offers effective 24-hour beta blockade

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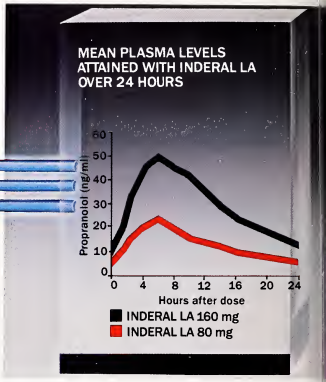
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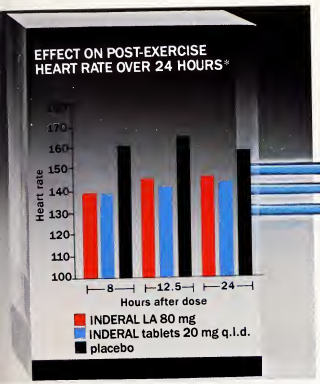
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Provides therapeutic benefit throughout the day and night

In placebo-controlled trials, INDERAL LA was found to provide sustained 24-hour beta blockade as measured by decrease in heart rate, systolic blood pressure, and rate-pressure product. Patients taking once-daily INDERAL LA receive continuous protection from dose to dose–with therapeutic response equivalent to multiple daily doses of INDERAL tablets.

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*INDERAL LA vs. placebo: $p<.05$ at all hours measured.

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NEW

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INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES



THE ONE TO COUNT ON FOR INITIAL THERAPY IN HYPERTENSION

Start with 80 mg once daily

The usual initial dose is 80 mg INDERAL LA whether used alone or with a diuretic. Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control.

When converting patients from other beta blockers including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary.

Unsurpassed convenience and simplicity

Enhanced patient compliance



THE ONE TO COUNT ON

AND ANGINA

Simplified core therapy begins with 80 mg once daily

Although individual patients may respond to various doses, the average optimal dose in angina pectoris is 160 mg once daily.

Compatible with other conventional antianginal therapies

The experience and protection of INDERAL

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

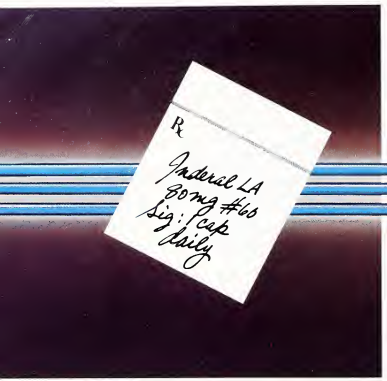
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80 mg 120 mg 160 mg

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THE ONE TO COUNT ON

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NOW WITH ONCE-DAILY DOSAGE

In hypertension, angina, and migraine—start with 80 mg once daily

Smooth 24-hour control

Unsurpassed simplicity and convenience

Enhanced patient compliance

Three strengths for prescribing convenience

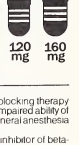
For arrhythmias, use conventional INDERAL® tablets

ONCE-DAILY
INDERAL® LA
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Ayerst®
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New York, N.Y. 10017

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ONCE-DAILY
INDERAL®
(PROPANOLOL HCl)
LONG ACTING CAPSULES



EF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

DERAL® LA brand of propranolol hydrochloride

ng) 120 mg, 160 mg Long Acting Capsules)

SCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol rochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

LOGICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor block agent possessing no other autonomic nervous activity. It specifically competes beta-adrenergic receptor stimulating agents for available receptor sites. When access to e-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator oses to beta receptor stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled predictable rate. Peak blood levels following dosing with INDERAL LA occur at about urs and the apparent plasma half-life is about 10 hours. When measured at steady state r a 24-hour period the areas under the propranolol plasma concentration-time curve ICs) for the capsules are approximately 60% to 65% of the AUCs for a comparable ded daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater atic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. er a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) rs then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four ses daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to intain effectiveness at the end of the dosing interval. In most clinical settings, however, ch has been shown to be of angina when there is little correlation between plasma levels and ical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of nventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour erobe responses of exercise tolerance and rate pressure product. INDERAL LA provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. long the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total ripheral resistance may increase initially, it readjusts to or below the pretreatment level with nore use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL s been shown to cause a small increase in serum potassium concentration when used in treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart any given level of effort by blocking the catecholamine-induced increases in the heart rate, stolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol y increase oxygen requirements by increasing left ventricular fiber length, end diastolic essure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade usually advantageous and is manifested during exercise by delayed onset of pain and reased exercise tolerance.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine- e or anesthetic-like membrane action which affects the cardiac action potential. The ndamental significance of this membrane action in humans is not established.

The mechanism of the antimigraine effect of propranolol has not been established. eta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be associated with bronchial constriction, bradycardia, ilure, and other manifestations of adrenergic blockade. In patients with chronic bronchal changes, sympathetic activity is detrimental to the patient. But there are also uations in which sympathetic stimulation is vital. For example, in patients with severely imaged hearts, adequate ventricular function is maintained by the sympathetic nerve drive ich must be preserved. In the presence of AV block, greater than first degree, beta ockade may prevent the necessary facilitating effect of sympathetic activity on conduction. eta blockade results in bronchial constriction by interfering with adrenergic bronchodilator ivity which must be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

DICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the manage- ent of hypertension. It may be used alone or used in combination with other antihypertensive nts, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of pertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for e long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. he effectiveness of propranolol in the treatment of a migraine attack that has started has not been tablished and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of mptomatic hypertrophic subaortic stenosis, especially to relieve exertional stress induced ngina, palpitations, and syncope. INDERAL LA also improves exercise performance. The ffectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of e elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. linical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus radycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is controlled by a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by eta blockade may precipitate more severe failure. Although beta blockers should be voided in overt congestive heart failure, if necessary, they can be used with close follow-up patients with a history of failure who are receiving digitalis and are receiving digitalis and uretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on eart muscle.

PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta lockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of eart failure, the patient should be digitalized and/or treated with diuretics, and the response bserved closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the explicit advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) - PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA-BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl) like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be carefully observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers. INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular System: Bradycardia; congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type

Central Nervous System: Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels Therefore, it may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval

HYPERTENSION – *Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks

ANGINA PECTORIS – *Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE – *Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily The dosage may be increased gradually to achieve optimum migraine prophylaxis If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks

HYPERTROPHIC SUBAORTIC STENOSIS – 80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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POETRY

This Is Just To Say*

WILLIAM CARLOS WILLIAMS, M.D., Rutherford

I have eaten
the plums
that were in
the icebox

and which
you were probably
saving
for breakfast

Forgive me
they were delicious
so sweet
and so cold

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ORIGINAL ARTICLE

William Carlos Williams Center for Performing Arts

MARK HILLRINGHOUSE*

Williams saw himself as an outpost both in the physical sense of being a doctor and in the metaphysical sense of his creative imagination which gushed forth onto prescription pads into poetry between seeing patients and making rounds at the hospital. The two fields only rarely interfered, and constantly fed into and reinforced each other. What Williams discovered for himself was, "That whatever was before him, in all its concrete strangeness and newness, was 'sufficient to itself and so to be valued.' It could be a brave new world anywhere."[1]

As a doctor, Williams had worked hard at the craft of medicine as he had worked at sharpening his craft of writing. On his sabbatical year in Europe, away from his practice, he even took time to attend lectures in pediatrics at the Children's Clinic in Vienna. This, he had done his whole life, a life both in medicine and in art, a life that was constantly trying to reexamine itself. As he said, "And that is why art is important . . . because it is the perfect type of all accomplishment—to which every activity, political, scientific approaches. . . ."[1]

And so it is important that another outpost, an arts center, should rise up and be named for the famous poet-doctor from Rutherford, one block away from his lifetime residence. For without a platform, the arts suffer; to have artists without an audience is equal to a physician with no patients.

"Here [in Rutherford] the world of art is nonexistent," Williams confessed.[1] So he had to go elsewhere for his weekly injections of culture, his Friday night treks into New York, or abroad for a year's sabbatical.

Had Williams lived to see an arts center grow out of his hometown he would have been truly amazed and delighted. For what he wanted was for America to turn to itself, to its past, to produce out of its own shining history, a unique and indigenous blend of cultural experience. The Williams Center has that potential—to captivate for a local audience the creative talent springing up everywhere in New Jersey in all the arts: poetry, dance, theatre, and music.

Already, the five million dollar complex of two movie cinemas, a restaurant, and recital hall, have begun to operate on raising that awareness, an awareness that can only grow and flourish in the years ahead (Figure). It all lies in the future, in the work being done now.

My perception as poetry director of this arts center rests entirely in the objective signs, healthy signs that reveal an ever-increasing growth in attendance. The Center has opened its doors and has produced chamber music recitals, poetry readings, lectures, and plays.

Williams would have liked the idea of an arts center that grew phoenix-like, from the fire-damaged Rivoli Theatre, a vaudeville stage and showplace for the big bands of the 1930s, that later became a movie house during the golden age of Hollywood, a movie house Williams himself attended, into finally, an arts center bearing his name. This is something Williams extolled in his writing, the process of changing the old into something fresh and new.

This arts center, only four years in the making, now awaits the finishing touches—the completion of its 1,800 seat Main Concert Hall and future home of the New Jersey Opera, Ballet, and Symphony. The only struggle left is to locate the funding needed, two million dollars, with which to restore that part of the center, the Rivoli Theatre part, to its full magnificence. The new sections—Marcus Hall, twin movie cinemas, Poet's Cafe, and meeting rooms, celebrated their grand opening on August 27, 1982.

*Mr. Hillringhouse is Poetry Director, William Carlos Williams Center for the Performing Arts, Rutherford.



Figure—*The William Carlos Williams Center for the Performing Arts,* Rutherford. Grateful acknowledgment is given to the Center for permission to reprint this photograph. Photo credit: Roy Wright.

North Jersey will have its own showcase. The Williams Center has combined the best in acoustical engineering with the most up-to-date designs in support facilities that include: dressing, warmup, and rehearsal rooms, showers, restrooms, performers' lounges, recording studio, spacious lobbies, elegant stairways, convenient entranceways, ramps, wheelchair areas, and elevators for the elderly and physically handicapped. Residents will be able to enrich their lives with first-rate productions of ballet, opera, theatre, classical music, jazz, and poetry readings.

The Williams Center will become, in Williams's phrase, a vortex, a focal point, for all the arts. ■

REFERENCE

1. Mariani P: *A New World Naked.* New York, NY, McGraw-Hill, 1982.

Paterson: Book 1*

WILLIAM CARLOS WILLIAMS, M.D., Rutherford

Paterson lies in the valley under the Passaic Falls
its spent waters forming the outline of his back. He
lies on his right side, head near the thunder
of the waters filling his dreams! Eternally asleep,
his dreams walk about the city where he persists
incognito. Butterflies settle on his stone ear.
Immortal he neither moves nor rouses and is seldom
seen, though he breathes and the subtleties of his
machinations
drawing their substance from the noise of the pouring river
animate a thousand automations. Who because they
neither know their sources nor the sills of their
disappointments walk outside their bodies aimlessly for the
most part,
locked and forgot in their desires—unroused.

—Say it, no ideas but in things—
nothing but the blank faces of the houses
and cylindrical trees
bent, forked by preconception and accident—
split, furrowed, creased, mottled, stained—
secret—into the body of the light!

From above, higher than the spires, higher
even than the office towers, from oozy fields
abandoned to grey beds of dead grass,
black sumac, withered weed-stalks,
mud and thickets cluttered with dead leaves—
the river comes pouring in above the city
and crashes from the edge of the gorge
in a recoil of spray and rainbow mists—

(What common language to unravel?
. . combed into straight lines
from the rafter of a rock's
lip.)

A man like a city and a woman like a flower
—who are in love. Two women. Three women.
Innumerable women, each like a flower.

But

only one man—like a city.

In regard to the poems I left with you; will you be so kind as to return them to me at my new address? And without bothering to comment upon them if you should find that embarrassing—for it was the human situation and not the literary one that motivated my phone call and visit.

Besides, I know myself to be more the woman than the poet; and to concern myself less with the publishers of poetry than with . . . living . . .

But they set up an investigation . . . and my doors are bolted forever (I hope forever) against all public welfare workers, professional do-gooders and the like.

Jostled as are the waters approaching
the brink, his thoughts
interlace, repel and cut under,
rise rock-thwarted and turn aside
but forever strain forward—or strike
an eddy and whirl, marked by a
leaf or curdy spume, seeming
to forget.

Retake later the advance and
are replaced by succeeding hordes
pushing forward—they coalesce now
glass-smooth with their swiftness,
quiet or seem to quiet as at the close
they leap to the conclusion and
fall, fall in air! as if
floating, relieved of their weight,
split apart, ribbons; dazed, drunk
with the catastrophe of the descent
floating unsupported
to hit the rocks: to thunder,
as if lightning had struck.

All lightness lost, weight regained in
the repulse, a fury of
escape driving them to rebound
upon those coming after—
keeping nevertheless to the stream, they
retake their course, the air full
of the tumult and of spray
connotative of the equal air, coeval,
filling the void.

And there, against him, stretches the low mountain.
The Park's her head, carved, above the Falls, by the
quiet
river; Colored crystals the secret of those rocks;
farms and ponds, laurel and the temperate wild cactus,
yellow flowered . . . facing him, his
arm supporting her, by the *Valley of the Rocks,* asleep.
Pearls at her ankles, her monstrous hair
spangled with apple-blossoms is scattered about into
the back country, waking their dreams—where the deer
run
and the wood-duck nests protecting his gallant
plumage (Figures 1, 2 and 3).

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Figure 1—*The Passaic Falls, Paterson, NJ.* 1967. Photography by George A. Tice.



Figure 2—*The Falls of the Passaic.* Anonymous. Photographed by J. Crilley. Grateful acknowledgment is given to The New Jersey State Museum Collection, Trenton, for permission to reprint the painting. Museum purchase.



Figure 3—*An Expression of a Silktown in New Jersey.* Oscar F. Bluemner, 1915. Grateful acknowledgment is given to The New Jers State Museum, Trenton, for permission to reprint this painting. Museum purchase, 1976.

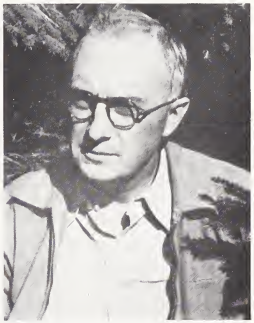
INTRODUCTION TO PROSE

On the following pages we present a small sample of the work penned by William Carlos Williams. His fiction is represented by *The White Mule, Jean Beicke,* and *The Use of Force;* his criticism by *A Matisse.*

The White Mule, Chapter 1, is a description of birth, written with a respect for feeling as well as a respect for reality. The description is clinically valid and poetically lovely—a description that could only have been written by the poet who was a physician.

In *The Use of Force,* Williams poses a dilemma as yet unsolved in pediatrics. When two goals or goods conflict, how do we rank their worth? How do we determine which is the better good? In this story, there is a little girl whose views about a medical examination are entitled to be respected. Our society concedes to the parents the right of determination.

Jean Beicke tells the story of an 11-month-old girl who dies from meningitis. Williams approached the piece with detached sensitivities yet with a sympathetic overtone.



William Carlos Williams. Photographed by Charles Sheeler. Grateful acknowledgment is given to New Directions Publishing Corp.

FICTION

White Mule, Chapter 1*

WILLIAM CARLOS WILLIAMS, M.D., Rutherford

She entered, as Venus from the sea, dripping. The air enclosed her, she felt it all over her, touching, waking her. If Venus did not cry aloud after release from the pressures of that sea-womb, feeling the new and lighter flood springing in her chest, flinging out her arms—this one did. Screwing up her tiny smeared face, she let out three convulsive yells—and lay still.

Stop that crying, said Mrs. D, you should be glad to get outa that hole.

It's a girl. What? A girl. But I wanted a boy. Look again. It's a girl, Mam. No! Take it away. I don't want it. All this trouble for another girl.

What is it? said Joe, at the door. A little girl. That's too bad. Is it all right? Yes, a bit small though. That's all right then. Don't you think you'd better cover it up so it won't catch cold? Ah, you go on out of here now and let me manage, said Mrs. D. This appealed to him as proper so he went. Are you all right, Mama? Oh, leave me alone, what kind of man are you? As he didn't exactly know what she meant he thought it better to close the door. So he did.

In prehistoric ooze it lay while Mrs. D wound the white twine about its pale blue stem with kindly clumsy knuckles and blunt fingers with black nails and with the wiped-off scissors from the cord at her waist, cut it—while it was twisting and flinging up its toes and fingers into the way—free.

Alone it lay upon its back on the bed, sagging down in the middle, by the smeared triple mountain of its mother's disgusted thighs and toppled belly.

The clotted rags were gathered. Struggling blindly against the squeezing touches of the puffing Mrs. D, it was lifted into a nice woolen blanket and covered. It sucked its under lip and then let out two more yells.

Ah, the little love. Hear it, Mam, it's trying to talk.

La, la, la, la, la, la, la! it said with its tongue—in the black softness of the new pressures—and jerking up its hand, shoved its right thumb into its eye, starting with surprise and pain and yelling and rolling in its new agony. But finding the thumb again at random it sobbingly subsided into stillness.

Mrs. D lifted the cover and looked at it. It lay still. Her heart stopped. It's dead! She shook the . . .

With a violent start the little arms and legs flew up into a tightened knot, the face convulsed again—then as the nurse sighed, slowly the tautened limbs relaxed. It did not seem to breathe.

And now if you're all right I'll wash the baby. All right, said the new mother drowsily.

In that two ridges lap with wind cut off at the bend of the neck it lay, half dropping, regrasped—it was rubbed with warm oil that rested in a saucer on the stove while Mrs. D with her feet on the step of the oven rubbed and looked it all over, from the top of its head to the shiny soles of its little feet.

About five pounds is my guess. You poor little mite, to come into a world like this one. Roll over here and stop wriggling or you'll be on the floor. Open your legs now till I rub some of this oil in there. You'll open them glad enough one of these days—if you're not sorry for it. So, in all of them creases. How it sticks. It's like lard. I wonder what they have that on them for. It's a hard thing to be born a girl. There you are now. Soon you'll be in your little bed and I wish I was the same this minute.

She rubbed the oil under the arm pits and carefully round the scrawny folds of its little neck pushing the wobbly head back and front. In behind the ears there was still that white grease of pre-birth. The matted hair, larded to the head, on the brow it lay buttered heavily while the whole back was caked with it, a yellow-white curd.

In the folds of the groin, the crotch where the genitals all bulging and angry red seemed presages of some future growth, she rubbed the warm oil, carefully—for she was a good woman—and thoroughly, cleaning her fingers on her apron. She parted the little parts looking and wondering at their smallness and perfection and shaking her head forebodingly.

The baby lay back at ease with closed eyes—lolling about as it was, lifted by a leg, an arm, and turned.

Mrs. D looked at the toes, counted them, admired the little perfect nails—and then taking each little hand, clenched tight at her approach, she smoothed it out and carefully anointed its small folds.

Into the little sleeping face she stared. The nose was flattened and askew, the mouth was still, the slits of the eyes

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vere swollen closed—it seemed.

You're a homely little runt, God pardon you, she said—ubbing the spot in the top of the head. Better to leave that —I've heard you'd kill them if you pressed on that too hard. They say a bad nurse will stop a baby crying by pressing here—a cruel thing to do.

She looked again where further back upon the head a soft ound lump was sticking up like a jockey cap askew. That'll ll go down, she said to herself wisely because it was not the irst baby Mrs. D had tended, nor the fifth nor the tenth nor he twentieth even.

She got out the wash boiler and put warm water in it. In hat she carefully laid the new-born child. It half floated, half sleep—opening its eyes a moment then closing them and esting on Mrs. D's left hand, spread out behind its neck.

She soaped it thoroughly. The father came into the kitchen vhere they were and asked her if she thought he could have a cup of coffee before he left for work—or should he go and get it at the corner. He shouldn't have asked her—suddenly t flashed upon his mind. It's getting close to six o'clock, he said. How is it? Is it all right?

He leaned to look. The little thing opened its eyes, blinked and closed them in the flare of the kerosene oil lamp close by n the gilded bracket on the wall. Then it smiled a crooked ittle smile—or so it seemed to him.

It's the light that hurts its eyes, he thought, and taking a dish towel he hung it on the cord that ran across the kitchen so as to cast a shadow on the baby's face.

Hold it, said Mrs, D, getting up to fill the kettle.

He held it gingerly in his two hands, looking curiously, shyly at that ancient little face of a baby. He sat down, resting it on his knees, and covered its still wet body. That little female body. The baby rested. Squirming in the tender grip of his guarding hands, it sighed and opened its eyes wide.

He stared. The left eye was rolled deep in toward the nose; the other seemed to look straight at his own. There seemed to be a spot of blood upon it. He looked and a cold dread started through his arms. Cross eyed! Maybe blind. But as he looked—the eyes seemed straight. He was glad when Mrs. D relieved him—but he kept his peace. Somehow this bit of moving, unwelcome life had won him to itself forever. It was so ugly and so lost.

The pains he had seemed to feel in his own body while the child was being born, now relieved—it seemed almost as if it had been he that had been the mother. It was his baby girl. That's a funny feeling, he thought.

He merely shook his head.

Coffee was cooking on the back of the stove. The room was hot. He went into the front room. He looked through the crack of the door into their bedroom where she lay. Then he sat on the edge of the disheveled sofa where, in a blanket, he had slept that night—and waited. He was a good waiter. Almost time to go to work.

Mrs. D got the cornstarch from a box in the pantry. She had to hunt for it among a disarray of pots and cooking things and made a mental note to put some order into the place before she left. Ah, these women with good husbands, they have no sense at all. They should thank God and get to work.

Now she took the baby once more on her lap, unwrapped it where it lay and powdered the shrivelling, gummy two inch stem of the gummy cord, fished a roll of Canton flannel from the basket at her feet and putting one end upon the little pad of cotton on the baby's middle wrapped the binder round it tightly, round and round, pinning the end in place across the back. The child was hard there as a board now—but did not wake.

She looked and saw a red spot grow upon the fabric. Tie it again. Once more she unwrapped the belly band. Out she took the stump of the cord and this time she wound it twenty times about with twine while the tiny creature heaved and vermiculated with joy at its relief from the too tight belly band.

Wrapping an end of cotton rag about her little finger, Mrs. D forced that in between the little lips and scrubbed those tender gums. The baby made a grimace and drew back from this assault, working its whole body to draw back.

Hold still, said Mrs. D, bruising the tiny mouth with sedulous care—until the mite began to cough and strain to vomit. She stopped at last.

Dried, diapered and dressed in elephantine clothes that hid it crinkily; stockinged, booted and capped, tied under the chin—now Mrs. D walked with her new creation from the sweaty kitchen into the double light of dawn and lamps, through the hallway to the front room where the father sat, to show him.

Where are you going? For a walk?, he said.

Look at it in its first clothes, she answered him.

Yes, he said, it looks fine. But he wondered why they put the cap and shoes on it.

Turning back again, Mrs. D held the baby in her left arm and with her right hand turned the knob and came once more into the smells of the birth chamber. There it was dark and the lamp burned low. The mother was asleep.

She put out the lamp, opened the inner shutters. There was a dim light in the room.

Waking with a start—What is it? the mother said. Where am I? Is it over? Is the baby here?

It is, said Mrs. D, and dressed and ready to be sucked. Are you flooding any?

Is it a boy? said the mother.

It's a girl, I told you before. You're half asleep.

Another girl. Agh, I don't want girls. Take it away and let me rest. God pardon you for saying that. Where is it? Let me see it, said the mother, sitting up so that her great breasts hung outside her undershirt. Lay down, said Mrs. D. I'm all right. I could get up and do a washing. Where is it?

She took the little thing and turned it around to look at it. Where is its face? Take off that cap. What are these shoes on for? She took them off with a jerk. You miserable scrawny little brat, she thought, and disgust and anger fought inside her chest, she was not one to cry—except in a fury.

The baby lay still, its mouth stinging from its scrub, its belly half strangled, its legs forced apart by the great diaper —and slept, grunting now and then.

Take it away and let me sleep. Look at your breasts, said Mrs. D. And with that they began to put the baby to the breast. It wouldn't wake.

The poor miserable thing, repeated the mother. This will fix it. It's its own mother's milk it needs to make a fine baby of it, said Mrs. D. Maybe it does, said the mother, but I don't believe it. You'll see, said Mrs. D.

As they forced the great nipple into its little mouth, the baby yawned. They waited. It slept again. They tried again. It squirmed its head away. Hold your breast back from its nose. They did.

Mrs. D squeezed the baby's cheeks together between her thumb and index finger. It drew back, opened its jaws and in they shoved the dripping nipple. The baby drew back. Then

for a moment it sucked.

There she goes, said Mrs. D, and straightened up with a sigh, pressing her two hands against her hips and leaning back to ease the pain in her loins.

The mother stroked the silky hair, looked at the gently pulsing fontanelle, and holding her breast with the left hand to bring it to a point, straightened back upon the pillows and frowned.

The baby ceased to suck, squirming and twisting. The nipple lay idle in its mouth. It slept. Looking down, the mother noticed what had happened. It won't nurse, Mrs. D. Take it away. Mrs. D come here at once and take this thing, I'm in a dripping perspiration.

Mrs. D came. She insisted it should nurse. They tried. The baby waked with a start, gagging on the huge nipple. It pushed with its tongue. Mrs. D had it by the back of the neck pushing. She flattened out the nipple and pushed it in the mouth. Milk ran down the little throat, a watery kind of milk. The baby gagged purple and vomited.

Take it. Take it away. What's the matter with it? You're too rough with it.

If you'd hold it up properly, facing you and not away off at an angle as if—Mrs. D's professional pride was hurt. They tried again, earnestly, tense, uncomfortable, one cramped over where she sat with knees spread out, the other half kneeling, half on her elbows—till anger against the little rebellious spitting imp, anger and fatigue, overcame them.

Take it away, that's all, said the mother finally.

Reluctantly, red in the face, Mrs. D had no choice but to do what she was told. I'd like to spank it, she said, flicking its fingers with her own.

What! said the mother in such menacing tones that Mrs. D caught a fright and realized whom she was dealing with. She said no more.

But now, the baby began to rebel. First its face got red, its whole head suffused, it caught its breath and yelled in sob and long shrill waves. It sobbed and forced its piercing litt voice so small yet so disturbing in its penetrating puniness mastering its whole surroundings till it seemed to madde them. It caught its breath and yelled in sobs and long shril waves. It sobbed and squeezed its yell into their ears.

That's awful, said the mother, I can't have it in this room. I don't think it's any good. And she lay down upon her back exhausted.

Mrs. D with two red spots in her two cheeks and serious jaw and a headache took the yelling brat into the kitchen. Dose it up. What else?

She got the rancid castor oil and gave the baby some. It fought and spit. Letting it catch its breath, she fetched the fennel tea, already made upon the range, and sweetening it poured a portion into a bottle, sat down and rather roughly told the mite to take a drink. There, drat you. Sweet to unsweeten that unhappy belly. The baby sucked the fermentative warm stuff and liked it—and wet its diaper after.

Feeling the wet through her skirt and petticoat and drawers right on her thighs, Mrs. D leaped up and holding the thing out at arms's length, got fresh clothes and changed it.

Feeling the nice fresh diaper, cool and enticing, now the baby grew red all over. Its face swelled, suffused with color. Gripping its tiny strength together, it tightened its belly band even more.

The little devil, said Mrs. D, to wait till it's a new diaper on.

And with this final effort, the blessed little thing freed itself as best as could—and it did very well—of a quarter pound of tarrish, prenatal slime—some of which ran down one leg and got upon its stocking.

That's right, said Mrs. D.

Jean Beicke*

WILLIAM CARLOS WILLIAMS, M.D., Rutherford

During a time like this, they kid a lot among the doctors and nurses on the obstetrical floor because of the rushing business in new babies that's pretty nearly always going on up there. It's the Depression, they say, nobody has any money so they stay home nights. But one bad result of this is that in the children's ward, another floor up, you see a lot of unwanted children.

The parents get them into the place under all sorts of pretexts. For instance, we have two premature brats, Navarro and Cryschka, one a boy and one a girl; the mother died when Cryschka was born, I think. We got them within a few days of each other, one weighing four pounds and one a few ounces more. They dropped down below four pounds before we got them going but there they are; we had a lot of fun betting on their daily gains in weight but we still have them. They're in pretty good shape though now. Most of the kids that are left that way get along swell. The nurses grow attached to them and get a real thrill when they begin to pick up. It's great to see. And the parents sometimes don't even come to visit them, afraid we'll grab them and make them take the kids out, I suppose.

A funny one is a little Hungarian Gypsy girl that's been up there for the past month. She was about eight weeks old maybe when they brought her in with something on her lower lip that looked like a chancre. Everyone was interested but the Wassermann was negative. It turned out finally to be nothing but a peculiarly situated birthmark. But that kid is still there too. Nobody can find the parents. Maybe they'll turn up some day.

Even when we do get rid of them, they often come back in a week or so—sometimes in terrible condition, full of impetigo, down in weight—everything we'd done for them to do over again. I think it's deliberate neglect in most cases. That's what happened to this little Gypsy. The nurse was funny after the mother had left the second time. I couldn't speak to her, she said. I just couldn't say a word I was so mad. I wanted to slap her.

We had a couple of Irish girls a while back named Cowley. One was a red head with beautiful wavy hair and the other a straight haired blonde. They really were good looking and not infants at all. I should say they must have been two and three years old approximately. I can't imagine how the parents could have abandoned them. But they did. I think they were habitual drunkards and may have had to beat it besides on short notice. No fault of theirs maybe.

But all these are, after all, not the kind of kids I have in mind. The ones I mean are those they bring in stinking dirty, and I mean stinking. The poor brats are almost dead sometimes, just living skeletons, almost, wrapped in rags, their heads caked with dirt, their eyes stuck together with pus and their legs all excoriated from the dirty diapers no one has had the interest to take off them regularly. One poor little pot we have now with a thin purplish skin and big veins standing out all over its head had a big sore place in the fold of its neck under the chin. The nurse told me that when she started to undress it it had on a shirt with a neckband that rubbed right into that place. Just dirt. The mother gave a story of having had it in some sort of home in Paterson. We couldn't get it straight. We never try. What the hell? We take 'em and try to make something out of them.

Sometimes, you'd be surprised, some doctor has given the parents a ride before they bring the child to the clinic. You wouldn't believe it. They clean 'em out, maybe for twenty five dollars—they maybe had to borrow—and then tell 'em to move on. It happens. Men we all know too. Pretty bad. But what can you do?

And sometimes the kids are not only dirty and neglected but sick, ready to die. You ought to see those nurses work. You'd think it was the brat of their best friend. They handle those kids as if they were worth a million dollars. Not that some nurses aren't better than others but in general they break their hearts over those kids, many times, when I, for one, wish they'd never get well.

I often kid the girls. Why not? I look at some miserable specimens they've dolled up for me when I make the rounds in the morning and I tell them: Give it an enema, maybe it will get well and grow up into a cheap prostitute or something. The country needs you, brat. I once proposed that we have a mock wedding between a born garbage hustler we'd saved and a little female with a fresh mug on her that would make anybody smile.

Poor kids! You really wonder sometimes if medicine isn't all wrong to try to do anything for them at all. You actually

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want to see them pass out, especially when they're deformed or—they're awful sometimes. Every one has rickets in an advanced form, scurvy too, flat chests, spindly arms and legs. They come in with pneumonia, a temperature of a hundred and six, maybe, and before you can do a thing, they're dead.

This little Jean Beicke was like that. She was about the worst you'd expect to find anywhere. Eleven months old. Lying on the examining table with a blanket half way up her body, stripped, lying there, you'd think it a five months baby, just about that long. But when the nurse took the blanket away, her legs kept on going for a good eight inches longer. I couldn't get used to it. I covered her up and asked two of the men to guess how long she was. Both guessed at least half a foot too short. One thing that helped the illusion besides her small face was her arms. They came about to her hips. I don't know what made that. They should come down to her thighs, you know.

She was just skin and bones but her eyes were good and she looked straight at you. Only if you touched her anywere, she started to whine and then cry with a shrieking, distressing sort of cry that no one wanted to hear. We handled her as gently as we knew how but she had to cry just the same.

She was one of the damnedest looking kids I've ever seen. Her head was all up in front and flat behind, I suppose from lying on the back of her head so long the weight of it and the softness of the bones from the rickets had just flattened it out and pushed it up forward. And her legs and arms seemed loose on her like the arms and legs of some cheap dolls. You could bend her feet up on the shins absolutely flat—but there was no real deformity, just all loosened up. Nobody was with her when I saw her though her mother had brought her in.

It was about ten in the evening, the interne had asked me to see her because she had a stiff neck, and how! and there was some thought of meningitis—perhaps infantile paralysis. Anyhow, they didn't want her to go through the night without at least a lumbar puncture if she needed it. She had a fierce cough and a fairly high fever. I made it out to be a case of broncho-pneumonia with meningismus but no true involvement of the central nervous system. Besides she had inflamed ear drums.

I wanted to incise the drums, especially the left, and would have done it only the night superintendent came along just then and made me call the ear man on service. You know. She also looked to see if we had an operative release from the parents. There was. So I went home, the ear man came in a while later and opened the ears—a little bloody serum from both sides and that was that.

Next day we did a lumbar puncture, tapped the spine that is, and found clear fluid with a few lymphocytes in it, nothing diagnostic. The X-ray of the chest clinched the diagnosis of broncho-pneumonia, there was an extensive involvement. She was pretty sick. We all expected her to die from exhaustion before she'd gone very far.

I had to laugh every time I looked at the brat after that, she was such a funny looking one but one thing that kept her from being a total loss was that she did eat. Boy! how that kid could eat! As sick as she was she took her grub right on time every three hours, a big eight ounce bottle of whole milk and digested it perfectly. In this depression you got to be such a hungry baby, I heard the nurse say to her once. It's a sign of intelligence, I told her. But anyway, we all got to be crazy about Jean. She'd just lie there and eat and sleep. Or she'd lie and look straight in front of her by the hour. Her eyes were blue, a pale sort of blue. But if you went to touch her, she'd begin to scream. We just didn't, that's all, unless we absolutely had to. And she began to gain in weight. Can you imagine that? I suppose she had been so terribly run down that food, real food, was an entirely new experience to her. Anyway she took her food and gained on it though her temperature continued to run steadily around between a hundred and three and a hundred and four for the first eight or ten days. We were surprised.

When we were expecting her to begin to show improvement, however, she didn't. We did another lumbar puncture and found fewer cells. That was fine and the second X-ray of the chest showed it somewhat improved also. That wasn't so good though, because the temperature still kept up and we had no way to account for it. I looked at the ears again and thought they ought to be opened once more. The ear man disagreed but I kept after him and the next day he did it to please me. He didn't get anything but a drop of serum on either side.

Well, Jean didn't get well. We did everything we knew how to do except the right thing. She carried on for another two—no I think it was three—weeks longer. A couple of times her temperature shot up to a hundred and eight. Of course we knew then it was the end. We went over her six or eight times, three or four of us, one after the other, and nobody thought to take an X-ray of the mastoid regions. It was dumb, if you want to say it, but there wasn't a sign of anything but the history of the case to point to it. The ears had been opened early, they had been watched carefully, there was no discharge to speak of at any time and from the external examination, the mastoid processes showed no change from the normal. But that's what she died of, acute purulent mastoiditis of the left side, going on to involvement of the left lateral sinus and finally the meninges. We might, however, have taken a culture of the pus when the ear was first opened and I shall always, after this, in suspicious cases. I have been told since that if you get a virulent bug like the streptococcus mucosus capsulatus it's wise at least to go in behind the ear for drainage if the temperature keeps up. Anyhow she died.

I went in when she was just lying there gasping. Somehow or other, I hated to see that kid go. Everybody felt rotten. She was such a scrawny, misshapen, worthless piece of humanity that I had said many times that somebody ought to chuck her in the garbage chute—but after a month watching her suck up her milk and thrive on it—and to see those alert blue eyes in that face—well, it wasn't pleasant. Her mother was sitting by the bed crying quietly when I came in, the morning of the last day. She was a young woman, didn't look more than a girl, she just sat there looking at the child and crying without a sound.

I expected her to begin to ask me questions with that look on her face all doctors hate—but she didn't. I put my hand on her shoulder and told her we had done everything we knew how to do for Jean but that we really didn't know what, finally, was killing her. The woman didn't make any sign of hearing me. Just sat there looking in between the bars of the crib. So after a moment watching the poor kid beside her, I turned to the infant in the next crib to go on with my rounds. There was an older woman there looking in at that baby also—no better off than Jean, surely. I spoke to her, thinking she was the mother of this one, but she wasn't.

Before I could say anything, she told me she was the older sister of Jean's mother and that she knew that Jean was dying and that it was a good thing. That gave me an idea—I hated to talk to Jean's mother herself—so I beckoned the woman to come out into the hall with me.

I'm glad she's going to die, she said. She's got two others ome, older, and her husband has run off with another oman. It's better off dead—never was any good anyway. ou know her husband came down from Canada about a ear and a half ago. She seen him and asked him to come ack and live with her and the children. He come back just ng enough to get her pregnant with this one then he left her gain and went back to the other woman. And I suppose nowing she was pregnant, and suffering, and having no noney and nowhere to get it, she was worrying and this one ever was formed right. I seen it as soon as it was born. I uess the condition she was in was the cause. She's got nough to worry about now without this one. The husband's one to Canada again and we can't get a thing out of him. I been keeping them, but we can't do much more. She'd work f she could find anything but what can you do with three ids in times like this? She's got a boy nine years old but her nother-in-law sneaked it away from her and now he's with is father in Canada. She worries about him too, but that lon't do no good.

Listen, I said, I want to ask you something. Do you think he'd let us do an autopsy on Jean if she dies? I hate to speak o her of such a thing now but to tell you the truth, we've worked hard on that poor child and we don't exactly know what is the trouble. We know that she's had pneumonia but hat's been getting well. Would you take it up with her for ne, if—of course—she dies.

Oh, she's gonna die all right, said the woman. Sure, I will. If you can learn anything, it's only right. I'll see that you get he chance. She won't make any kick, I'll tell her.

Thanks, I said.

The infant died about five in the afternoon. The pathologist was dog-tired from a lot of extra work he'd had to do due to the absence of his assistant on her vacation so he put off the autopsy till next morning. They packed the body in ice in one of the service hoppers. It worked perfectly.

Next morning they did the postmortem. I couldn't get the nurse to go down to it. I may be a sap, she said, but I can't do it, that's all. I can't. Not when I've taken care of them. I feel as if they're my own.

I was amazed to see how completely the lungs had cleared up. They were almost normal except for a very small patch of residual pneumonia here and there which really amounted to nothing. Chest and abdomen were in excellent shape, otherwise, throughout-not a thing aside from the negligible pneumonia. Then he opened the head.

It seemed to me the poor kid's convolutions were unusually well developed. I kept thinking it's incredible that that complicated mechanism of the brain has come into being just for this. I never can quite get used to an autopsy.

The first evidence of the real trouble—for there had been no gross evidence of meningitis—was when the pathologist took the brain in his hand and made the long steady cut which opened up the left lateral ventricle. There was just a faint color of pus on the bulb of the choroid plexus there. Then the diagnosis all cleared up quickly. The left lateral sinus was completely thrombosed and on going into the left temporal bone from the inside the mastoid process was all broken down.

I called up the ear man and he came down at once. A clear miss, he said. I think if we'd gone in there earlier, we'd have saved her.

For what? said I. Vote the straight Communist ticket.

Would it make us any dumber? said the ear man.

FICTION

The Use of Force

WILLIAM CARLOS WILLIAMS, M.D., Rutherford

They were new patients to me, all I had was the name, Olson. Please come down as soon as you can, my daughter is very sick.

When I arrived I was met by the mother, a big startled looking woman, very clean and apologetic who merely said, Is this the doctor? and let me in. In the back, she added. You must excuse us, doctor, we have her in the kitchen where it is warm. It is very damp here sometimes.

The child was fully dressed and sitting on her father's lap near the kitchen table. He tried to get up, but I motioned for him not to bother, took off my overcoat and started to look things over. I could see that they were all very nervous, eyeing me up and down distrustfully. As often, in such cases, they weren't telling me more than they had to, it was up to me to tell them; that's why they were spending three dollars on me.

The child was fairly eating me up with her cold, steady eyes, and no expression to her face whatever. She did not move and seemed, inwardly, quiet; an unusually attractive little thing, and as strong as a heifer in appearance. But her face was flushed, she was breathing rapidly, and I realized that she had a high fever. She had magnificent blonde hair, in profusion. One of those picture children often reproduced in advertising leaflets and the photogravure sections of the Sunday papers.

She's had a fever for three days, began the father and we don't know what it comes from. My wife has given her things, you know, like people do, but it don't do no good. And there's been a lot of sickness around. So we tho't you'd better look her over and tell us what is the matter.

As doctors often do I took a trial shot at it as a point of departure. Has she had a sore throat?

Both parents answered me together, No . . . No, she says her throat don't hurt her.

Does your throat hurt you? added the mother to the child. But the little girl's expression didn't change nor did she move her eyes from my face.

Have you looked?

I tried to, said the mother, but I couldn't see.

As it happens we had been having a number of cases of diphtheria in the school to which this child went during that month and we were all, quite apparently, thinking of that, though no one had as yet spoken of the thing.

Well, I said, suppose we take a look at the throat first. I smiled in my best professional manner and asking for the child's first name I said, come on, Mathilda, open your mouth and let's take a look at your throat.

Nothing doing.

Aw, come on, I coaxed, just open your mouth wide and let me take a look. Look, I said opening both hands wide, I haven't anything in my hands. Just open up and let me see.

Such a nice man, put in the mother. Look how kind he is to you. Come on, do what he tells you to. He won't hurt you.

At that I ground my teeth in disgust. If only they wouldn't use the word "hurt" I might be able to get somewhere. But I did not allow myself to be hurried or disturbed but speaking quietly and slowly I approached the child again.

As I moved my chair a little nearer suddenly with one cat-like movement both her hands clawed instinctively for my eyes and she almost reached them too. In fact she knocked my glasses flying and they fell, though unbroken, several feet away from me on the kitchen floor.

Both the mother and father almost turned themselves inside out in embarrassment and apology. You bad girl, said the mother, taking her and shaking her by one arm. Look what you've done. The nice man . . .

For heaven's sake, I broke in. Don't call me a nice man to her. I'm here to look at her throat on the chance that she might have diphtheria and possibly die of it. But that's nothing to her. Look here, I said to the child, we're going to look at your throat. You're old enough to understand what I'm saying. Will you open it now by yourself or shall we have to open it for you?

Not a move. Even her expression hadn't changed. Her breaths however were coming faster and faster. Then the

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attle began. I had to do it. I had to have a throat culture for er own protection. But first I told the parents that it was ntirely up to them. I explained the danger but said that I ould not insist on a throat examination so long as they ould take the responsibility.

If you don't do what the doctor says you'll have to go to he hospital, the mother admonished her severely.

Oh yeah? I had to smile myself. After all, I had already allen in love with the savage brat, the parents were con-emptible to me. In the ensuing struggle they grew more and nore abject, crushed, exhausted while she surely rose to nagnificent heights of insane fury of effort bred of her terror of me.

The father tried his best, and he was a big man but the fact hat she was his daughter, his shame at her behavior and his lread of hurting her made him release her just at the critical noment several times when I had almost achieved success, ill I wanted to kill him. But his dread also that she might nave diphtheria made him tell me to go on, go on though he himself was almost fainting, while the mother moved back and forth behind us raising and lowering her hands in an agony of apprehension.

Put her in front of you on your lap, I ordered, and hold both her wrists.

But as soon as he did the child let out a scream. Don't, you're hurting me. Let go of my hands. Let them go I tell you. Then she shrieked terrifyingly, hysterically. Stop it! Stop it! You're killing me!

Do you think she can stand it, doctor! said the mother.

You get out, said the husband to his wife. Do you want her to die of diphtheria?

Come on now, hold her, I said.

Then I grasped the child's head with my left hand and tried to get the wooden tongue depressor between her teeth. She fought, with clenched teeth, desperately! But now I also had grown furious—at a child. I tried to hold myself down but I couldn't. I know how to expose a throat for inspection. And I did my best. When finally I got the wooden spatula behind the last teeth and just the point of it into the mouth cavity, she opened up for an instant but before I could see anything she came down again and gripping the wooden blade between her molars she reduced it to splinters before I could get it out again.

Aren't you ashamed, the mother yelled at her. Aren't you ashamed to act like that in front of the doctor?

Get me a smooth-handled spoon of some sort, I told the mother. We're going through with this. The child's mouth was already bleeding. Her tongue was cut and she was screaming in wild hysterical shrieks. Perhaps I should have desisted and come back in an hour or more. No doubt it would have been better. But I have seen at least two children lying dead in bed of neglect in such cases, and feeling that I must get a diagnosis now or never I went at it again. But the worst of it was that I too had got beyond reason. I could have torn the child apart in my own fury and enjoyed it. It was a pleasure to attack her. My face was burning with it.

The damned little brat must be protected against her own idiocy, one says to one's self at such times. Others must be protected against her. It is social necessity. And all these things are true. But a blind fury, a feeling of adult shame, bred of a longing for muscular release are the operatives. One goes on to the end.

In a final unreasoning assault I overpowered the child's neck and jaws. I forced the heavy silver spoon back of her teeth and down her throat till she gagged. And there it was—both tonsils covered with membrane. She had fought valiantly to keep me from knowing her secret. She had been hiding that sore throat for three days at least and lying to her parents in order to escape just such an outcome as this.

Now truly she *was* furious. She had been on the defensive before but now she attacked. Tried to get off her father's lap and fly at me while tears of defeat blinded her eyes.

A Matisse*

WILLIAM CARLOS WILLIAMS, M.D., Rutherford

On the French grass, in that room on Fifth Ave., lay that woman who had never seen my own poor land. The dust and noise of Paris had fallen from her with the dress and underwear and shoes and stockings which she had just put aside to lie bathing in the sun. So too she lay in the sunlight of the man's easy attention. His eye and the sun had made day over her. She gave herself to them both for there was nothing to be told. Nothing is to be told to the sun at noonday. A violet clump before her belly mentioned that it was spring. A locomotive could be heard whistling beyond the hill. There was nothing to be told. Her body was neither classic nor whatever it might be supposed. There she lay and her curving torso and thighs were close upon the grass and violets.

So he painted her. The sun had entered his head in the color of sprays of flaming palm leaves. They had been walking for an hour or so after leaving the train. They were hot. She had chosen the place to rest and he had painted her resting, with interest in the place she had chosen.

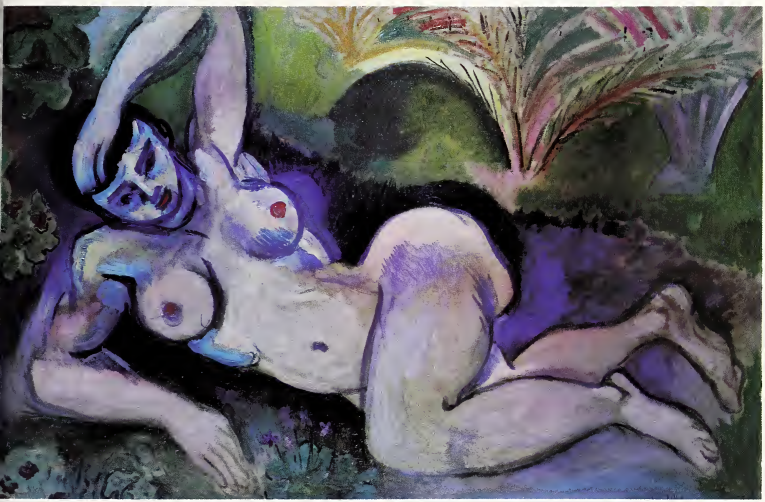
It had been a lovely day in the air.—What pleasant women are these girls of ours! When they have worn clothes and take them off it is with an effect of having performed a small duty. They return to the sun with a gesture of accomplishment.—Here she lay in this spot today not like Diana or Aphrodite but with better proof than they of regard for the place she was in. She rested and he painted her.

It was the first of summer. Bare as was his mind of interest in anything save the fullness of his knowledge, into which her simple body entered as into the eye of the sun himself, so he painted her. So she came to America.

No man in my country has seen a woman naked and painted her as if he knew anything except that she was naked. No woman in my country is naked except at night.

In the French sun, on the French grass in a room on Fifth Avenue, a French girl lies and smiles at the sun without seeing us (Figure).

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igure—*The Blue Nude.* Henri Matisse, 1907. Grateful acknowledgment is given to The Baltimore Museum of Art: The Cone Collection, ormed by Dr. Claribel Cone and Miss Etta Cone of Baltimore, Maryland.

ORIGINAL ARTICLE

William Carlos Williams: A New World Naked*

PAUL MARIANI**

It had indeed been quite a life: the uphill struggle of an American revolutionary to establish—against the incredible odds of neglect, misinterpretation, dismissal—an American poetic based on a new measure and a primary regard for the living, protean shape of the language as it was actually used. It had been a fight, a magnificent fight, against the academy, against the numbing sclerosis of the universities, against the very scholars of the language (there were none, Williams insisted), against special interests of all kinds, and he had had to create a strategy and sometimes even desperate homemade measures where none had existed before. He had had to fight long and hard, only to be repeatedly dismissed by critics (who should have known better) as a minor, inconsequential poet, a latter-day imagist, a clown, a bumpkin incapable of serious consecutive thought.

Williams had of course heard it all countless times. And yet he kept on writing his way because he knew that he was right, as even Pound had to admit tacitly and as hundreds of other poets would soon become convinced. But Williams was not after personal glory. In fact he despaired of its ever coming his way and felt uncomfortable with it when it finally did come. He disliked being lionized and he had to ask younger poets not to call him father or maestro. He wanted rather to be viewed as one of the gang, as part of a community of disinterested craftsmen, members of a guild, who would have the dedication of scientists in the field passionately searching for answers. He was self-effacing, hardworking to the point of its finally killing him, and generous as few poets have been generous. He was a man of rare honesty, easy on others but extremely hard on himself, a man who had made mistakes, who had faltered or run up blind alleys in his single-minded "selfish" pursuit of his poetry. But he was above all a lover, a lover of people, a lover of his world, a lover of his craft. He wanted a poetry that would speak with an authentic accent directly to his own time, for he was a citizen of his world—which he knew intimately—in ways that few others had come to match. And, in his insistent manner, often alone, he did manage to effect a revolution in the word that is still being felt, a revolution that has affected and will probably continue to affect poetry in America and elsewhere far into the next century.

In midwinter 1956 Williams, then 72, had written Louis Zukofsky to say that he had a picture postcard sitting on his desk:

> sent to me by a friend, a woman living in Brasil now, whom I met in the nut house when I was there. It shows four old musicians walking poorly clad in the snow from left to right between—or approaching a village no doubt somewhere in Europe. They are all scrunched together their instruments in their hands trudging along. I mean to keep the card there a long time as a reminder of our probable fate as artists. I know just what is going on in the minds of those white haired musicians.

His was a life devoid of the dramatic tragedy or intense pathos of some other poets, a life lived by choice in the provinces, attending the needs of the people he came up against in Rutherford, Hackensack, Passaic, Carlstadt, Lyndhurst, Garfield, Paterson. But it was a life too that kept in constant contact with the intellectual currents of New York as that city grew from a provincial capital into the leading cultural center of the world. His was, then, a representative life and he was himself a Representative Man as Whitman had been in Emerson's sense of that phrase: a figure who in his actions and his words had raised his particular world to the level of art with a single-mindedness and persistence approaching the heroic. What made it difficult for many Americans, let alone others less centrally concerned, to accept this estimation of Williams was that they could not believe that the major poet could happen here, here in the postlapsarian, gritty yet burgeoning world of America. It was Williams's genius to have seen—70 years ago—that it could happen here . . . and that it did. ■

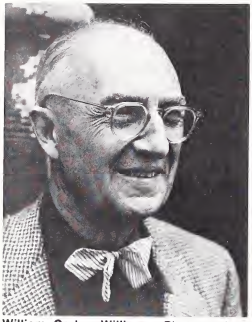
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William Carlos Williams. Photographed by John D. Schiff. Grateful acknowledgment is given to New Directions Publishing Corp.

In some respects, William Carlos Williams, M.D., was one of the best-known physicians in New Jersey. He was one of the few with a truly international reputation—in his case, world-wide acclaim as a poet. Williams was born in Rutherford in 1883 and he died there in his sleep on March 4, 1963. He received his medical degree at the University of Pennsylvania in 1906. He was a pioneer in pediatrics, one of the first men in the United States to make it a specialty. He did graduate work in pediatrics in Germany and in Switzerland in 1907 and 1908 when practically no such teaching was available here.

Dr. Williams first became known as a poet in 1909 when a slim volume won a national prize. Since then, blue ribbons in poetry and literature came his way in a regular procession. The list of awards and prizes and famous poems and odes is a long one. So is the list of honorary degrees and fellowships. But to the people of Bergen County, he was known chiefly as a pediatrician—and a good one.*

*Original obituary, published May 1963.

CME CALENDAR

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

CARDIOLOGY

Oct.

4 The Role of Potassium in Cardiac Function

8 Dx and Treatment of Ischemic Heart Disease
9-10 a.m.—Holy Name Hospital, Teaneck
(Holy Name Hospital and AMNJ)

5 Medical Long-Term Management of Coronary Heart Disease
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

12 Diabetes, Exercise, and the Heart
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

15 Cardiovascular Research Update
2:30-5 p.m.—Hyatt Regency, New Brunswick
(American Heart Association, NJ Affiliate, and AMNJ)

19 Congestive Heart Failure
1-2:30 p.m.—Christ Hospital, Jersey City
(AMNJ)

MEDICINE

Oct.

4 Hymenoptera Sensitivity and Immunological Ramifications
7:30 p.m.—Burdette Tomlin Hospital, Cape May Court House
(AMNJ)

4 The Role of Potassium in Cardiac Function

11 Drug Related Pulmonary Disorder

18 Dx and Treatment of Ischemic Heart Disease
9-10 a.m.—Holy Name Hospital, Teaneck
(Holy Name Hospital and AMNJ)

5 Types of Insulin and Modes of Administration

19 Congestive Heart Failure
1-2:30 p.m.—Christ Hospital, Jersey City
(AMNJ)

5 Medical Long-Term Management of Coronary Heart Disease

12 Common Dermatologic Problems in an Office Practice

19 Genetic Disorders of Clinical Significance in the Adult

26 Cancer Epidemiology and Prevention
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

5 Calcium Antagonists and Their Uses
9-10 a.m.—Alexian Brothers Hospital, Elizabeth
(Knoll Pharmacy and AMNJ)

5 Alcoholism
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(AMNJ)

5 Medical Ground Rounds
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

5 Proper Use of Antibiotics in Closed Hospital Settings
1:30 p.m.—Essex County Hospital Center, Cedar Grove
(AMNJ)

5 Endocrine Conferences
12 3:30-5 p.m.—Rotates between Newark
19 Beth Israel Medical Center, University
26 Hospital, United Hospitals Medical Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

6 Medical Grand Rounds
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section, AMNJ)

7 Medical Grand Rounds
11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section, AMNJ)

7 Renal Conferences in Nephrology
4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMNJ)

12 Monoclonal Antibodies: The New Serology
1:30-5:30 p.m.—Drew University Campus, Madison
(Drew University, CIBA-Geigy Pharmaceutical Division, and AMNJ)

12 Intestinal Neoplasia
2-5 p.m.—Saint Barnabas Medical Center, Livingston
(NJ Gastroenterological Society and AMNJ)

12 Diabetes, Exercise, and the Heart

18 Infections in the Elderly
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

13 Newer Therapeutic Aspects of Biliary and Pancreatic Disease
11 a.m.-12:30 p.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

13 Ophthalmology Associated with Systemic Diseases
2-3 p.m.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

18 Herpes Infections
12 noon-1 p.m.—St. Mary's Hospital, Orange
(AMNJ)

19 Acquired Immunodeficiency Syndrome (AIDS)
9-10 a.m.—Warren Hospital, Phillipsburg
(AMNJ)

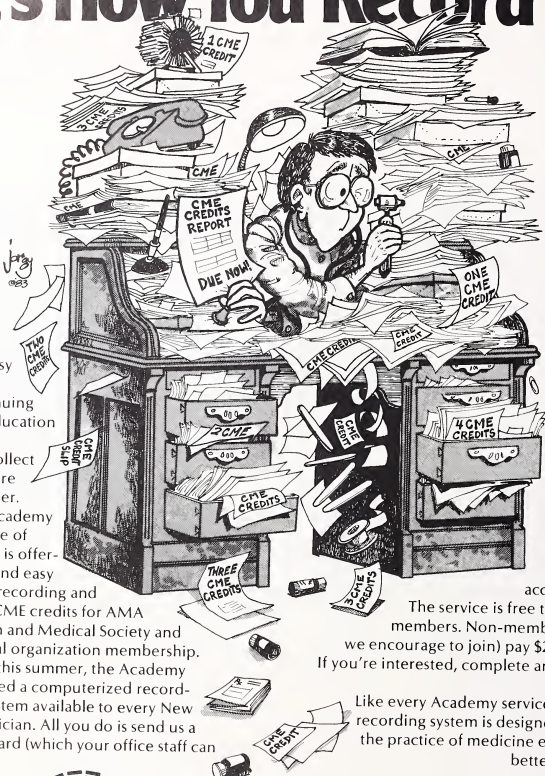
19 Nonoperative Management of Chronic Back Pain
10-11:30 p.m.—South Bergen Hospital, Hasbrouck Heights
(AMNJ)

19 Pharmacology and Treatment of Chronic Obstructive Pulmonary Disease
1-2 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

19 Hypothyroidism Update
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

19 Rutgers Dermatological Conference
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy 1, New Brunswick
(UMDNJ and AMNJ)

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Topic To Be Announced
6:30 p.m.—The Manor, West Orange
(Urology Section, AMNJ)

Clinical Applications of Tumor Markers
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

Nonpharmacologic Approaches to Hypertension
8 a.m.-5 p.m.
9 a.m.-12:40 p.m.—Resorts International, Atlantic City
(UMDNJ and AMNJ)

ov.

Current Therapy of COPD
9-10 a.m.—Holy Name Hospital, Teaneck
(Holy Name Hospital and AMNJ)

Pulmonary Manifestations of Connective Tissue Diseases and Medications
8:30 a.m.-1 p.m.—Rutgers Medical School, Piscataway
(Arthritis Foundation, NJ Chapter, NJ Rheumatism Association, and AMNJ)

Medical Grand Rounds
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

Geriatric Pharmacology
1:30 p.m.—Essex County Hospital Center, Cedar Grove
(AMNJ)

Hypertension Update 1983

Diagnosis and Management of the Patient with Low Back Pain

Recent Developments in Renal Dialysis and Transplantation

Evaluation of Diarrhea and Its Treatment

Evaluation and Management of Urinary Abnormalities in an Office Practice
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

Endocrine Conferences
3:30-5 p.m.—Rotates between Newark Beth Israel Medical Center, University Hospital, United Hospitals Medical Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

Medical Grand Rounds
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section, AMNJ)

Immunological Markers in the Diagnosis of Leukemia and Lymphoma
11 a.m.-12:30 p.m.—St. Joseph's Hospital,
(St. Joseph's Hospital and Medical Center and AMNJ)

Update on Cutaneous Malignancies
8-10 p.m.—Bergen County Medical Society, Hackensack
(NJ Medical Women's Association and AMNJ)

Medical Grand Rounds
11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section, AMNJ)

Renal Conferences in Nephrology

4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMNJ)

Lung Cancer
7:30 p.m.—Burdette Tomlin Memorial Hospital, Cape May Court House
(AMNJ)

Crises in the Critical Care Units
8:30 a.m.-2:45 p.m.—Hilton Hotel, Tinton Falls
(NJ Society of Critical Care Medicine and AMNJ)

Immunology Update
2-3 p.m.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

Toxic Shock Syndrome
12 noon—St. Mary's Hospital, Orange
(AMNJ)

Rutgers Dermatological Conference
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

Crystal-Induced Joint Diseases

Hyperlipidemia-Update
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center, Lyons and AMNJ)

Lower Extremity Ischemia: How, When, Why?

Anaerobic Infection
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

Evaluation of the Bleeding Patient
5-6:30 p.m.—Somerset Medical Center,

The *Journal* of the Medical Society of New Jersey
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September, 1983

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Somerville
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17 Regional Hospital Meeting Case Presentations
8-10 p.m.—Somerset Medical Center, Somerville
(NJ Gastroenterological Society and AMNJ)

22 FVIII Inhibitor Management
6:30-10 p.m.—Landmark Inn, Woodbridge
(NJ Blood Club and Hematology Section, AMNJ)

30 Emergency Care
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(AMNJ)

NEUROLOGY/PSYCHIATRY

Oct.

3 Psychiatric Case Conference
10 7:30-11:30 a.m.—Trenton Psychiatric
17 Hospital
24 *(Trenton Psychiatric Hospital and*
31 *AMNJ)*

5 Approach to the Clinically Suicidal Patient
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

6 Treatment Refusals in Mental Health

13 Depression-Recent Advances in Diagnosis and Treatment

20 Culture and Its Effect on Health
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

15 Prevention of Mental Illness in Children
9 a.m.-4:30 p.m.—The Mountainside Hospital, Montclair
(The Mountainside Hospital and AMNJ)

18 Alcoholism
3-4 p.m.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

26 Age-Related Clinical Issues
9:30 a.m.-4:30 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

Nov.

2 Clinical Treatment of Depression in Office Practice
9-10 a.m.—Alexian Brothers Hospital, Elizabeth
(Mead Johnson and AMNJ)

3 Hypnosis in Medical Practice
12 noon—J.F. Kennedy Medical Center, Edison
(AMNJ)

3 Psychological Assessment of Dementia and Depression in the Aged

10 Treatment and Research Outcomes in Schizophrenia

17 The Cult Phenomena and Treatment
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

15 Drug Addiction
3 p.m.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

16 Industrial-Occupational Medicine and Psychiatry
9:30 a.m.-4:30 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

OBSTETRICS/GYNECOLOGY

Nov.

22 Ovarian Cancer
9-10 a.m.—Holy Name Hospital, Teaneck
(Holy Name Hospital and AMNJ)

PATHOLOGY

Nov.

3 Genetic Etiology of Cancer

10 Genetic Control of the Transformed Tumorigenic Phenotypes

17 Transforming Proteins of DNA and RNA Viruses
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

12 Surgical Pathology of the Testes and Its Appendage
9 a.m.-1:00 p.m.—Rutgers Medical School, Piscataway
(NJ Society of Pathologists and AMNJ)

PEDIATRICS

Oct.

15 Prevention of Mental Illness in Children
8:30 a.m.-4:30 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital)

18 Advances of Pediatric Cardiology
8:30-10:30 p.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

19 Symposium on Pediatric Trauma
7:15 a.m.—Point Pleasant Hospital
(Point Pleasant Hospital)

26 Atypical Neuromotor Development: Early Identification and Treatment of Young Children
8:15 a.m.-4:00 p.m.—John F. Kennedy Medical Center, Edison
(AMNJ)

Nov.

10 Advances in Neonatology
9 a.m.—Freehold Area Hospital
(AMNJ)

22 Common Problems in the Adolescent Patient
8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

RADIOLOGY

Oct.

6 The Use of Newer Radiological Techniques in Pediatrics
9-10 a.m.—Freehold Area Hospital
(AMNJ)

9 Advanced Echocardiography
10 9 a.m.-5 p.m.—Nassau Inn, Princeton
(The National Foundation of Non-invasive Diagnostics and AMNJ)

Nov.

5 Real-Time, Cross-Sectional Sector Scanning
9 a.m.-5 p.m.—Nassau Inn, Princeton
(The National Foundation of Non-invasive Diagnostics and AMNJ)

16 Dinner Meeting—Carcinoma of the Cervix
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

SURGERY

Oct.

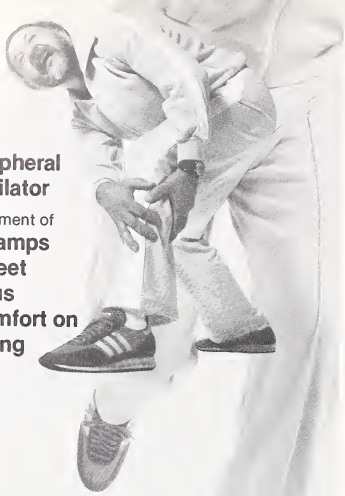
6 Oncology
13 4-6 p.m.—Institute for Medical
20 Research, Copewood St., Camden
27 *(Institute for Medical Research and AMNJ)*

25 Impotence-How I Conquered It
8:30-9:30 p.m.—Englewood Club, 114 E. Palisade Ave., Englewood
(Englewood Surgical Society and AMNJ)

Nov.

16 Examination of Compensable Injuries
7:15 a.m.—Point Pleasant Hospital
(Point Pleasant Hospital)

22 Head and Neck Tumors in Children
8:30-9:30 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)



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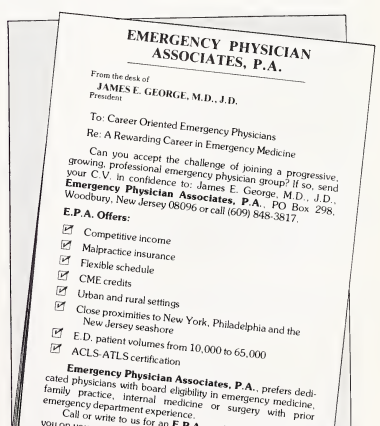
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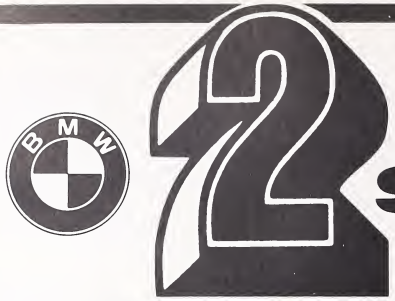
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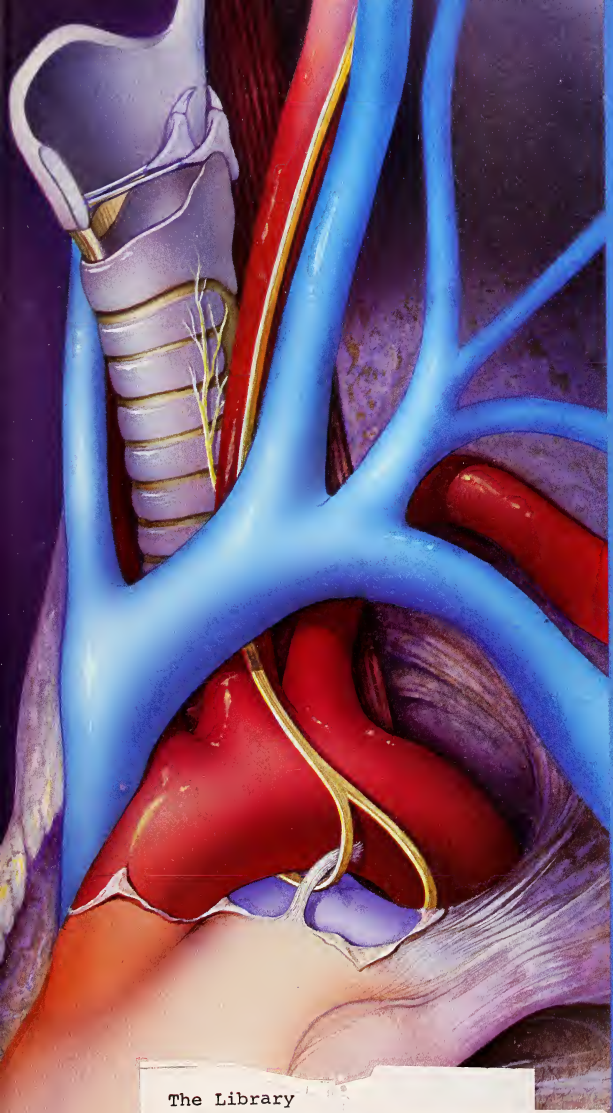
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Hospital and Commercial Toxic Screens
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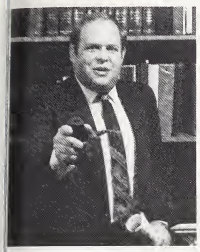
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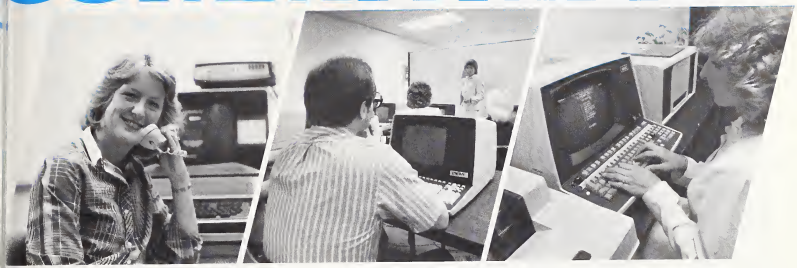
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On The Cover: Idiopathic fibrosing mediastinitis is an invasive process that constricts the mediastinal structures. To the multiple symptomatology of the disease, the authors of our cover story include paralysis of the vocal cords. The article on page 841 describes the case report of a 61-year-old male. The cover illustration is by Glenna Deutsch.

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The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update, and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

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Submit two **manuscripts** that must be typewritten and double-spaced on 8-1/2" by 11" paper. This material is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 50-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8-1/2" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

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The **summary** of the article should no exceed 250 words; it should contain onl essential facts.

References should not exceed 35 cita tions except in review articles, an should be cited consecutively in the tex by numbers in parentheses at the end o the sentence. The reference list should b typewritten and double-spaced on sepa rate 8-1/2" by 11" sheets in the numer ical order in which they are first cited in the text. The style of reference is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis.* New York, NY, McGraw-Hill, 1969, Pp. 42-48.

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Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

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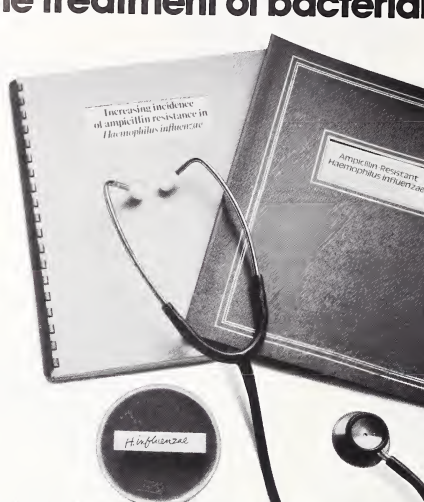
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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-5]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[2]

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Brief Summary Consult the package literature for prescribing information

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindications: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, lincosamides, penicillins, and cephalosporins); therefore, it is important to consider this diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile.* Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive Direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematology studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the maternal or in Coombs' tests of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made before each dose. Safe use of Ceclor in the presence of severely impaired renal function has not been established.

Prescribing Ceclor in the absence of a proven or suspected infection is not indicated.

Ceclor should be given with caution to patients with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in hamsters given three times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500 mg doses. Average levels were 0.18, 0.25, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are presented below and are listed below.

Gastrointestinal—Nausea and vomiting occur in about 2.5 percent of patients and include diarrhea (1 in 75).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity—reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests have been noted in 1 in 200 patients. Cases of serum-sickness-like reactions erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. The onset of these reactions usually occurs 7 days or more after initiation of therapy and subsides within a few days after cessation of the drug. No serious sequelae have been reported. Administration of corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 20 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Clinical Relationship Unclear but—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 66).

Hemic/Lymphatic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 43).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(9617829)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporin group and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information

References

1 Antimicrob Agents Chemother, 8:91, 1975
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5 Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), p 1800, Washington, D.C., American Society for Microbiology 1978
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8 Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p 487, New York, John Wiley & Sons, 1979

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Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

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MEMBERSHIP NEWSLETTER

MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 3

NO-FAULT INSURANCE

Medical fees are of no significance in the cost of automobile insurance in New Jersey.

Personal Injury Protection (PIP) benefits which include funeral expenses, hospital costs, podiatry, chiropractic, dental, medical, and other expenses also include compensation for lost wages. According to the insurance industry and the State Insurance Department, PIP benefits constitute 20 percent of the "loss dollar."

When asked what percentage of the loss dollar was attributable to medical expenses, the Commissioner of Insurance stated, "I don't know." When asked by what factor rates would be reduced if no payments were made to physicians, the Commissioner said, "I can't answer that."

It is an accepted concept in health economics that physicians' fees are no more than 15 to 20 percent of the health care expenditure. Assuming they are 20 percent, their maximum effect under no-fault would be 4 percent, but more likely is to be 2 percent.

Existing state statutes provide that physicians cannot bill accident cases at a different rate than patients when there is no third-party liability (*N.J.S.A.* 45:9-27.5 to 27.7). Likewise, a regulation of the State Board of Medical Examiners provides that a physician may not charge an excessive fee.

Medical fees are reviewed carefully and the no-fault fee schedules are not necessary, indicated, or workable. A medical fee schedule would resolve nothing!

OSTEOPATHIC USE OF M.D.

On August 1, 1983, the Appellate Division of the Superior Court rendered a decision in the case of Doctor Philip B. Eatough, Jr., et al. *v* Board of Medical Examiners, *A-1022-82 T1.* The case subsequently was reported in the newspapers. The accounts were inaccurate and do not truly represent the opinion delivered by the Court. In order to avoid unnecessary confusion, the following are the essential elements of the Court's opinion:

"The Degree Designation Rule, *N.J.A.C.* 13:35-4.1 of the State Board of Medical Examiners is invalid." That rule provides that licensed physicians shall identify themselves only by the degree designation which is imprinted on the license that was issued to them, i.e. J. Smith, M.D. or J. Smith, D.O.

"The Advertising Rule, *N.J.A.C.* 13:35-6.13 of the State Board of Medical Examiners is invalid." That rule provides that when advertising via any written publication, the license degree must be designated.

"The Board is enjoined from inscribing a degree designation of M.D. or D.O. on the license issued to practice medicine and surgery in New Jersey." This means that licenses will be issued in the name of the individual without any degree designation placed thereon.

"Osteopathic physicians who have not earned the M.D. degree may not hold themselves out as M.D.'s." The M.D. degree is not the generic term for physician. Only those individuals who have earned that degree can present themselves as possessing it.

The decision of the Court is predicated upon the meaning and intent of the statutes to grant a single type of license regardless of the degree used to qualify. The Court reasoned that the license must be issued to the individual to practice medicine and surgery, and that individual may but is not obligated to list his degree. When he does present a degree listing, it must indeed be one that he has earned.

PRESCRIPTION DRUG ABUSE

Prescription drug abuse came under attack as the Florida Medical Association, Massachusetts Medical Society, and the Michigan Medical Society endorsed field tests of the AMA model for identifying "script doctors." Several other medical societies are gearing up to help pinpoint the sources of drug diversion in their states. Participating medical societies will work with existing state and federal drug enforcement agencies as well as educate physician members about the ruses that addicts and others employ to obtain drugs.

Current federal data show that prescribable drugs are involved in almost 60 percent of all drug-related emergency room visits and 70 percent of all drug-related deaths. Some of these drugs are channeled into illicit use through diversion and theft at the wholesale level, or are illegally manufactured or imported, but the vast majority (80 to 90 percent) reach "the street" through diversion from individual practitioners, retail pharmacies, and hospitals.

Acting on recommendations of the AMA Council on Scientific Affairs, the AMA supported the development of PADS (Prescription Abuse Drug Synthesis) for identifying potential script doctors by name, address, and registration number. The AMA will give the PADS model to state officials at no cost, and will provide on-site technical assistance in implementing it. The model employs sophisticated data analysis systems that currently are available from national, state, and local agencies. Thus the use of PADS does not require states to invest in additional computer hardware or software, and should not involve significant expenditures of staff time.

For further information, write to Bonnie B. Wilford, Health and Human Behavior Program, AMA headquarters, or telephone (312) 751-6579.

JUDGE ORDERS SBME TO KEEP PROMISE

A Superior Court Judge in Mercer County ordered the State Board of Medical Examiners to abide by its agreement and end the suspension of a northern New Jersey doctor's license on July 13, 1983.

The Board, through its Deputy Attorney General, Michael Karpoff, entered into a stipulation wherein a physician's license was to be suspended for a period of three months beginning on April 13, 1983. Thereafter, the Board sought to extend the time of the suspension for an additional seven days since the Board Chairman, Dr. Albano, had not actually signed the order until April 20, 1983. Repeated requests to the Board to act in accordance with the representations of Mr. Karpoff to terminate suspension on July 13, 1983, were denied. The doctor then went to the Superior Court asking the Court to order the Board to keep its promise. The Judge ordered the Board to do what it said it would do.

MEDICAL ADVERTISING

Many advertisements offering financial inducement to commence treatment recently have come to the attention of the Board of Medical Examiners from various types of health practitioners licensed by the Board. The ads in question appear to have a common element: they inform the public that the physician (or chiropractor or other Board licensee) will undertake to provide health care to patients who wish the doctor to accept payments made by insurance companies on their behalf. The Board recognizes that this offer can be a significant benefit to a patient who is unable to pay immediately for medical services rendered, and who seeks a practitioner who is willing to wait for payment to be made by a third-party insurer.

N.J.A.C. 13:35-6.13(b) allows a Board licensee to provide information to the public respecting the availability of various services and of the usual fees for routine services, as well as other pertinent information. This certainly can include indication of willingness to accept payment made by third-party carriers (a distinct benefit since there almost invariably is some time delay between delivery of the health care service and receipt of payment from the insurance carrier). However, the same rule also prohibits referring to prices for professional services where those references may be misleading, deceptive, false, or fraudulent; it also prohibits the offering of gratuitous services to all persons without discrimination and as an inducement to come into the office, or discounts offered for the same purpose.

The advertisements coming to the attention of the Board appear to fall into certain categories:

1. Some of the ads assert that the doctor will "accept assignment"—meaning that the doctor will accept as payment in full whatever payment the insurance company is willing to make for that particular service, in accordance with the particular insurance contract. However, these ads fail to alert the consumer that not all medical services are covered by insurance contracts in general or that the service may not be covered by a particular contract. The consumer will not learn this until after the service has been rendered and billed, and the consumer thereby may be misled into undergoing an elective type of medical treatment without being prepared to pay the bill which the consumer now finds must be paid in full directly and personally.

2. Some of the ads proclaim to the reader that there will be "no out-of-pocket costs." Most of these ads fail to point out that many insurance contracts require the consumer to pay a deductible before subsequent coverage will be available. Again the consumer has been misled as to the real costs of the care undertaken.

3. Some of the ads fail to point out that many insurance contracts require the patient to pay the fee in part (i.e. copayment) with the insurance company paying the balance of the fee. This applies also to Medicare insurance coverage.

4. Some ads offer "a public service spinal examination" at the practitioner's office, implying that there will be no charge for a "preliminary spinal examination." This is a direct violation of the Board's rule *N.J.A.C.* 13:35-6.13 prohibiting solicitation, because it is not a community health public service but in fact takes place in the office setting where the potential especially is great for abuse, intimidation, and coercion of the patient in accepting additional treatment for which a fee shall be charged.

5. One of the same chiropractic ads proceeded to follow its offer of "a public service spinal examin-

tion" with the additional offer that "for the next 30 days, that [named] center will be accepting insurance assignment as payment in full for extensive health care treatments.* A patient may indeed come to that chiropractor's office in the naive belief that whatever care that person needs will be within the definition of "extensive health care treatments" and may learn belatedly that they will have incurred a substantial bill which will not be covered by the third-party payor. Moreover, the broad scale of insurance assignment acceptance for everyone—but only for 30 days—may induce persons who really do not need care to seek it out and to incur the expense relying upon someone else to pay for it. The ambiguity inherent in the qualification that the offer is good only upon the chiropractor's "review" of a given policy needs no comment.

In short, all of these ads present substantial potential for abuse and are not acceptable within the parameters of *N.J.A.C.* 13:35-6.13. Some involve a direct inducement to violate the insurance contract provisions between the patient and the third-party carrier. Others involve a violation by the health care provider of that person's arrangement with the third-party carrier. Regrettably, it is believed that many of these advertisers are simply billing the third-party carrier for a higher fee, by increasing the amount of the bill to cover the deductible or the copayment which the advertiser offers to "absorb."

It also should be noted that most, if not all, health care providers who agree to be participating doctors in an insurance plan, sign a certification on the claim form attesting to the fact that the fee charged is "the usual and customary fee." Where the provider now has offered, through advertising, to accept lower fee for each service, the provider has in effect decreased that provider's "usual and customary fee." While the large-scale lowering of fees undoubtedly is in the public interest, that provider must recognize that he or she cannot then attempt to bill the insurance carrier for a higher sum because this would constitute an increasingly convoluted scheme of "two-tier billing": one fee for persons without insurance and a higher fee for the same service for those with insurance, plus the additional misrepresentation as to just what the fee for the service is.

The Board will continue to review each matter presented on an individual case-by-case basis for the determination of appropriate corrective action and/or sanctions for rule violation. However, we take this opportunity to place Board licensees on additional notice that the above described ads are improper and are violative of Board rule because of their misleading nature.

It should be noted that the prohibition on solicitation and misleading representations is unrelated to the privilege of adjusting an individual fee. A Board licensee always has discretion to negotiate a particular fee with an individual patient, taking into account any factors deemed pertinent to that physician-patient relationship. The Board rule is explicit on that subject: "This clause shall not be construed to relate to the negotiation of fees between licensees and patients or clients, or to prohibit the rendering of professional services for which no fee is charged."

*This offer subject to our review of your assignment of policy and benefits. Patient is responsible for initial deductible and $5 for the preliminary examination.

ADVERTISING INFORMATION

The following is being republished by request from the Judicial Council.

13:35-6.13 Provision of information to the public

(a) "Licensee" for the purpose of this regulation means a person possessing a plenary license to practice medicine and surgery, a podiatrist, a chiropractor, a physical therapist, or a director of a bioanalytical laboratory.

(b) A licensee in the state of New Jersey may provide information to the public, by publication in a dignified manner in newspapers or comparable written publications concerning: education, certification, or appointment, location and availability of services, fees for routine professional services, and other pertinent information about the licensee's practice. On any such publication, license degree must be designated. To the extent that information provided to the public by the licensee may be misleading, the licensee shall provide clarification, such as, but not limited to, whether additional charges may be incurred for related services when fees are stated.

(c) Information provided to the public in accordance with section (b) of this section shall not by form, manner, or content be such as to solicit patients. Solicitation is prohibited. Solicitation shall include, but is not limited to, public information which may be found by the New Jersey State Board of Medical Examiners, as:

1. False, fraudulent, deceptive, misleading, or flamboyant;
2. Representing intimidation or undue pressure;
3. Using testimonials;
4. Guaranteeing any service or guaranteeing that satisfaction or cure will result from the professional services offered;
5. Offering gratuitous services or discounts in connection with published services, but this clause shall not be construed to relate to the negotiation of fees between licensees and patients or clients, or to prohibit the rendering of professional services for which no fee is charged;
6. Making claims of professional superiority;
7. Stating or including prices for professional services which are false, deceptive, or misleading.

(d) The information which may be provided to the public is limited to the printed media and any such information provided by a licensee in any other form is expressly prohibited.

(e) Any violation of the foregoing rule may be considered as the basis for suspension or revocation proceedings being instituted against the licensee.

(f) This rule supersedes any prior rule to the extent inconsistent therewith.

FEDERAL LEGISLATION AND REGULATIONS

Personal Service Corporations. The AMA responded to a proposed IRS regulation that would provide for reallocation of income between a personal service corporation and its employee-owners where the corporation is formed or availed of primarily to evade or avoid federal income taxes and substantially all of the services of the corporation are performed for one other corporation, partnership, or other entity. The regulation creates an inference that any personal service corporation which does not meet a safe harbor test established in the regulation has as its principal purpose the avoidance or evasion of federal income tax. The Association recommended that the regulation be amended to provide for consideration of the facts and circumstances of each specific case to determine the principal purpose for which the corporation was formed. (Letter to Roscoe L. Egger, Jr., Commissioner of Internal Revenue, Internal Revenue Service; May 23, 1983.)

Federal Election Commission. The American Medical Association supports a provision in regulations of the Federal Election Commission that would permit the political action committees of membership organizations to solicit families of members. This provision would grant membership organizations the same rights that corporate and labor political action committees have had with regard to solicitation of family members. (Letter to Danny Lee McDonald, Chairman, Federal Election Commission; May 24, 1983.)

Medicare/Medicaid: Beneficiary Cost-Sharing Requirements. The AMA submitted testimony to the Health Subcommittee of the Senate Finance Committee on FY84 budget proposals to revise beneficiary cost-sharing requirements under the Medicare and Medicaid programs. The Association statement responded to Medicare proposals to increase copayments and develop catastrophic coverage, to freeze physician reimbursement, to increase Part B deductibles and premiums, to modify program eligibility, and to eliminate deductibles for certain laboratory services. The statement also examined Medicaid proposals to mandate copayments, and to decrease matching payments. The AMA cautioned against setting unrealistic budget targets that could result in limiting access to and the availability of health care for beneficiaries of the Medicare and Medicaid programs. (Statement to the Health Subcommittee of the Senate Finance Committee; May 31, 1983.)

DEA Registration Fees. The AMA expressed its support for the Drug Enforcement Administration's proposal to increase the fee schedule for DEA registration of persons who manufacture, distribute, or dispense controlled substances. The Association indicated that the proposed fee schedule is reasonable in relation to DEA's cost of performing its important drug abuse control activities. (Letter of June 3, 1983, to the Drug Enforcement Administration.)

Medicaid: Buy-In Inpatient Definition. On June 4, 1983, the American Medical Association submitted comments to the Health Care Financing Administration concerning states "buying-in" to the Medicare Part B program for Medicare-eligible Medicaid beneficiaries, and a proposed redefinition of the terms "inpatient" and "outpatient" for purposes of determining Medicaid benefits. The AMA supported the proposal to give states greater flexibility in determining situations where they will pay deductibles and copayments when purchasing Medicare services for Medicare-eligible Medicaid beneficiaries. The Association recommended revisions to the proposed redefinitions to allow determinations of patient status based on individual situations as opposed to strict reliance on the duration of stay.

Medicaid Overpayment Reporting Requirements. The AMA submitted a letter responding to a proposed rule by HCFA to require state Medicaid agencies to identify and report overpayments and tentative overpayments made to Medicaid providers, and to establish procedures for HCFA to recover the federal share of established overpayments. The Association recommended that the proposal be modified to authorize a finding of an overpayment only after all parties concerned have exhausted their rights of full administrative and judicial review and appeal. (Letter to the Health Care Financing Administration; June 6, 1983.)

REPORTABLE DISEASES

a. The following diseases are declared to be reportable to the State Department of Health for purposes of this code: Amebiasis; Anthrax; Atypical Mycobacterioses; Babesiosis; Botulism; Brucellosis; *Campylobacter fetus* diseases; Dengue; Diphtheria; Encephalitis, Infectious (specify); Food/Water-Borne disease; Giardiasis; Guillain-Barré syndrome; Hepatitis, Type A, Type B, Non-A, Non-B, unspecified; Hydatid disease; Kawasaki disease (Mucocutaneous Lymph Node syndrome); Legionellosis, including Legionnaires' disease, Pontiac Fever, and diseases caused by atypical *Legionella-like* organisms; Leprosy; Leptospirosis; Lyme disease; Malaria; Measles; Meningitis, Infectious (specify); Meningococcal disease; Mumps; Pertussis; Plague; *Pneumocystis carinii* pneumonia; Poliomyelitis; Psittacosis; Rabies; Rat Bite fever; Relapsing fever, louseborne; Reye's syndrome; Rickettsial diseases, including Q fever, Rickettsialpox, Rocky Mountain Spotted fever, Typhus fever; Rubella (German Measles), including Congenital Rubella syndrome; Salmonellosis; Shigellosis; Smallpox; Tetanus; Toxic Shock syn-

drome; Trachoma; Trichinosis; Tuberculosis; Tularemia; Typhoid fever; Venereal diseases, Chancroid, Gonorrhea, Granuloma Inguinale, Lymphogranuloma Venereum, Ophthalmia Neonatorum, Syphilis; Viral Hemorrhagic fevers including (but not limited to) Ebola, Lassa, Marburg; diseases caused by *Vibrio* species, including Cholera, Yersiniosis, and Yellow fever.

b. The following diseases are declared to be reportable immediately by telephone: Botulism; Cholera; Diphtheria; Food/Water-Borne disease; Measles; Meningococcal diseases; Plague; Poliomyelitis; Rabies; Smallpox; Syphilis, Infectious; and Viral Hemorrhagic fevers, including (but not limited to) Ebola, Lassa, Marburg.

c. For purposes of research, surveillance and in response to technological developments in disease control, the State Commissioner of Health is empowered to amend the list of diseases to be reported.

LEGISLATIVE UPDATE

S-1813—Pronouncement of Death by Registered Nurses and Execution of Death Certificates. This bill opposed by the Medical Society of New Jersey, passed the Senate and was before the Assembly. Assembly amendments adopted June 23, 1983, provide that only physicians can execute the certification of death. RN's may make pronouncements of death and provide the particulars when those deaths occur in the home, place of residence of the deceased, or a nursing home or long-term care facility.

A-1371—Breast Cancer. This bill, which detailed the nature and type of consent that physicians must acquire prior to performing surgery for breast cancer, has been opposed by the Medical Society of New Jersey. An Assembly Committee Substitute for **A-1371** was passed in the Assembly. It provides that the State Department of Health shall prepare a booklet on the topic and make it available to hospitals and physicians. Physicians must present the appropriate patients with copies and answer questions regarding its contents.

E. & W. BLANKSTEEN ANNUAL REPORT

Accident and Health Disability Insurance, a comprehensive disability program, affords a monthly benefit of up to $5,000 during total disability due to injury or sickness. The program consists of: the Short-Term (Basic) Plan and the Long-Term Plan. The plans differ primarily in the length of time for which benefits are payable. For an accident disability, the Basic Plan pays up to five years; the Long-Term Plan pays up to a lifetime. For a sickness disability, the Basic Plan pays up to two years; the Long-Term to age 65 and over.

All of our accident and health policies have the guaranteed Conversion Provision Rider. Briefly, this Rider provides that, if the Nationwide were unilaterally to terminate any of its accident and health insurance programs for members of the Society, the Company is committed to issue a guaranteed renewable policy for the same benefits as are provided for in the doctor's original policy. There currently are 5,173 disability policies in force, with some members carrying two or three policies.

The Society's Major Expense Plan is underwritten by the Nationwide Life Insurance Company. This program especially is designed to work in conjunction with any Blue Cross and/or Blue Shield contract one may carry. The combination of the new $200 deductible Million-Dollar Major Expense Plan and some basic hospital coverage can provide excellent protection for you. Currently, there are 1,776 members participating in the Plan.

The coverage consists of two parts: basic coverage, providing after a $200 deductible $15,000 of benefits, covering $40 a day private-room allowance, nursing benefits, and services and supplies out of the hospital. Inhospital care is handled by Blue Cross or a similar plan. Umbrella coverage is designed to take over where Blue Cross leaves off and becomes operative when $15,000 of umbrella covered expenses have been incurred. Umbrella covered expenses consist of 100 percent of full semiprivate hospital care, including miscellaneous hospital expenses, as well as full nursing charges in hospital and 80 percent of certain services and supplies out of the hospital. Payments are made under the million dollar coverage to the extent that they have not been paid by other policies, including this one. Physicians' and surgeons' fee coverage also is available.

Unmarried dependent children are covered to age 25. All members who are under age 70, their spouses under age 70, and members' employees and their families are eligible to apply. At eligibility for Medicare, coverage for such person automatically becomes modified basic coverage, with a $15,000 maximum for each covered person and with a deductible of $750, or the amount of covered expense payable by Medicare, whichever is the greater. Medicare covered expense includes hospital miscellaneous services. The optional professional-fee coverage does not continue for those eligible for Medicare. Full coverage continues for covered persons not eligible for Medicare.

Our Hospital-Money Plan, provides $40, $60, $80, and $100 for each day of hospital confinement up to a maximum of 365 days for any one confinement. It can cover member, spouse, and dependent children. Benefits under this Plan were increased and premiums reduced for all policies renewing after February 1981. At present, 221 members participate in the program.

Many of our members find that their overhead expenses have become quite high, with employees' salaries, rentals, and other fixed expenses in connection with the practice. Our Professional Overhead Expense Plan is underwritten by the National Casualty Company. It provides up to $10,000 monthly benefit, beginning with day 31 of total disability, for as long

as two full years. Currently, 666 members are covered under this Plan.

Since January 1981, we have been offering our members another life insurance plan, in addition to the Nationwide Life and Bankers Life Plans. This plan, underwritten by the Transamerica Occidental Life Insurance Company of California, provides from $50,000 to $1,000,000 of annual, renewable term insurance. Members' spouses, children, and employees also may be covered. The cost is affordable and coverage is guaranteed renewable to age 75. With the Occidental Life Plan, a total of $1,250,000 is available to members applying prior to attainment of age 64. Currently, over 2,100 members are covered under the Nationwide Life, Bankers Life, and Occidental Plans, with approximately $56,000,000 of insurance in force. Since inception of these programs, death claims amounting to $5,142,000 have been paid.

The Occidental Life Plan particularly is useful to members because of the nonmedical limits, which are extremely generous. For example, members under age 30 can apply for up to $300,000; members 36 to 40, up to $150,000; and members 41 to 45, up to $100,000, without a mandatory physical examination.

Our Six Point, High-Limit Accident Insurance Plan, with the Nationwide Life Insurance Company, provides up to $200,000 for accidental death benefit, with dismemberment benefit, loss of sight, exposure, disappearance, and even a total disability feature.

The Short-Term (Basic) Plan, Long-Term Plan, Major Expense Plan, Hospital-Money Plan, Six Point, High-Limit Accident Insurance Plan, Overhead Expense Plan, and Life Insurance Plans are adaptable for use in professional corporations, and the necessary assignment forms are available upon request from the Administrator of the Plans.

All the above Plans are administered by the E. & W. Blanksteen Agency, 75 Montgomery Street, Jersey City, NJ 07302, or at 201-333-4340 or 800-742-2849.

PHYSICIANS' SERVICES

Present AMA policy which supports freedom of patients to choose their source of care and freedom of physicians to choose their method of payment—including fee-for-service, capitation, or salary—continues to be appropriate.

Within the fee-for-service approach, current AMA policy supports the basing of third-party payment levels on the "usual and customary or reasonable" concept, and the majority of private and public payors use the "UCR" concept in establishing payment levels. However, the increasing costs resulting from this approach have caused both private and public payors to be caught between mounting pressure to constrain plan outlays on the one hand, and continuing consumer demand for comprehensive coverage of physicians' services on the other.

As one result, the "reasonable charge" used by payors—particularly public payors—in determining payment levels no longer reflects the actual charges made by most physicians, because of infrequent updating of fee profiles, percentile cut-offs on customary charge data, and annual percentage caps on prevailing charge increases.

In addition, pressure is increasing on physicians to accept the payor-determined reasonable charge as payment in full (except for allowed deductibles or coinsurance)—i.e. to become "participating physicians." Such pressure is exerted through: plan or company contracts which increasingly allow assignment of benefits or make payment only when services are provided by participating physicians; beneficiary misunderstandings of "explanation of benefit" letters and resulting patient/physician friction; "hold harmless communications" from payors to subscribers; and increased consideration nationally of mandatory assignment or fee schedules under Medicare.

As these trends continue, patients increasingly will be restricted to "participating" providers as a condition for insurance coverage. Eventually, physicians' remuneration will be determined solely by third-party payors for the great majority, if not all, of the professional services they render—with what the Council believes will be a resulting inevitable mediocrity in the quality of medical care.

Accordingly, the Council believes that the Association should seriously consider recommending that third parties change to an indemnity system of payment for physicians' services, i.e. paying a set amount for services rather than some proportion of the "usual and customary or reasonable" charge. Such a set amount would be determined by the payor itself on the basis of claims experience, public demand, competition, and other relevant factors.

Such a change would benefit patients by: insuring their continued access to care not through external regulation of fees but through market forces; increasing both physicians' and patients' sensitivity to costs and quality of care provided; allowing them continued freedom of choice rather than being increasingly restricted to "participating" providers as a condition of coverage; and facilitating understanding and comparison of insurance coverages.

For third parties, rate determination would be simpler under an indemnity approach. Payors could establish premiums on the basis of prospective analysis of what the plan pays rather than on a statistical array of physician charges. Administrative costs should be significantly less. For government programs especially it provides an alternative which permits budgetary restraints without further restrictions on type or duration of services covered or massive increases in enrollee copayment.

For physicians, this approach could bring improved patient-physician interaction, since neither physician nor patient will have false expectations of the amount of third-party payment. Uncoupling third-party payment from physicians' charges could act to reduce

legislative and political pressure for mandating physician "participation" as a condition of payment, and help preserve for physicians the freedom to charge what they believe to be a fair and equitable fee, subject only to normal and effective market constraints.

The Council on Medical Service believes that a change of this import in AMA policy should be considered carefully by this House with their constituents over the next six months. The Council also will continue its study, and will submit recommendations at the 1983 Interim Meeting.

NJ POISON INFORMATION AND EDUCATION SYSTEM

Advice regarding the medical management of acute and chronic poisonings from a variety of products will be available 24 hours a day, 7 days a week including weekends and holidays. NJPIES can supply data on drugs, biologicals, chemicals, household products, and pesticides. They use the most up-to-date data systems to assure a caller with prompt, accurate information. Their staff has been selected carefully and trained to help with poisoning problems. Their only responsibility is to handle poison exposure calls.

The poison information center will respond to calls from the public and will direct victims needing hospital care to their nearest hospital emergency room. The poison center will inform that emergency room of their expected arrival and provide the medical staff with advice as to correct management.

The poison information center also will help coordinate the use of ambulance or rescue squads. First and "back-up" responders can access the poison center directly and receive up-to-the-minute information regarding the treatment of poisonings. At times, this may prevent the unnecessary transport of a victim of a noncritical poison exposure to a treating facility. In such a circumstance, the poison center may be able to initiate therapy in the home and take responsibility for followup. This will relieve the rescue squad of its obligation and make its service more efficient. Further, in patients requiring therapy and transport, the poison center can provide information directly to the first responder; this may provide the opportunity to initiate therapy at the site or in transit, thus saving valuable time. The poison center can alert the emergency room of the treating facility of the case and provide them with advance knowledge of the patient and suggestions for management. All of these poison center services promote a more efficient use of rescue, emergency, and ambulance squad services and provide for a high level of quality medical care of the poisoned patient.

The poison center will followup on all poison exposure calls. All calls will be returned at specified intervals, so that their status can be checked. These call-backs enable the staff to provide education to the caller regarding prevention of future exposures and proper treatment for poison exposures. The poison center will explain the use of syrup of ipecac and suggest that every caller keep a one-ounce bottle of syrup of ipecac for every household member.

The system is under the direction of Dr. Steven Marcus, a physician who is board certified in medical toxicology. Dr. Marcus is responsible for assuring that callers to the poison system receive the highest quality of care currently available. The day-to-day operation of the center and the direct supervision of the telephone answering service will be under the direction of Dr. Brent Whitehead. Dr. Whitehead possesses a doctoral degree in pharmacy with over five years of experience in poison information and treatment. He will coordinate the services for the center. The "poison specialists" are the professionals responsible for answering the phones. Trained in medicine, nursing, or pharmacy, they have received intensive training in accessing of poison information and in responding to inquiries.

The poison system can be reached through its toll-free telephone line, 800-962-1253, or through regular phone service, 201-926-8005. In addition, the poison system maintains equipment to handle telephone inquiries from the deaf via phone TTY service at both ends; this can be accessed through 201-926-8008.

If you would like any further information or clarification about the service or would like to receive posters and phone stickers, please call the Poison Control Center at 201-926-8005 or write to Steven M. Marcus, M.D., NJ Poison Information and Education System, 201 Lyons Avenue, Newark, NJ 07112.

CORRECTION: DONALD F. SMITH & ASSOCIATES ANNUAL REPORT

In the August *Membership Newsletter,* a portion of the annual report of Donald F. Smith & Associates (page 577) was missing. Below please find the completed information:

The Committee on Medical Defense and Insurance is pleased with the progress of the MSNJ statewide Blue Cross/Blue Shield and Major Medical Programs that provide exceptionally comprehensive coverage and benefits. The Committee will continue to work toward providing MSNJ members with the most comprehensive health insurance coverage available at competitive costs. Excellent service in claims handling and enrollment also will continue to be a top priority. Should you have any questions or suggestions regarding any of the MSNJ programs, please feel free to contact the Plan Administrator at Donald F. Smith & Associates, One Airport Place, Route 206 North, P.O. Box 2197, Princeton, NJ 08540. Or call, 609-924-8700 or 201-622-6046.

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Consent, Diagnosis, and the Malpractice Crisis

Most lawsuits against physicians are based on allegations of failure to meet the proper standards of patient care. However, lawsuits may result even when accepted standards of care have been met and the patient has benefited from the treatment. This may be the case if there has been a failure to obtain the patient's consent to the medical treatment.

General consent principles are derived from the law of battery. A battery is defined legally as the intentional and unauthorized touching of another person. Assault is defined legally as the threat of a battery. The law of assault and battery generally gives recognition to the individual's right to be free from unwarranted interference with one's body and to determine what should be done to one's own body.

Thus, if an emergency is not present, medical procedures or treatment provided in the absence of the patient's consent constitute battery, for which the physician may be held liable, even though the patient has received no injury as a result of the care provided.

The mere obtaining of the patient's consent is not legally sufficient in many circumstances. Courts have ruled that patients must have adequate information upon which to base their decision whether to submit to medical diagnosis or treatment.

Courts and legislatures throughout the nation have struggled with the concept of "informed consent." In New Jersey, the law of informed consent derives from case law. New Jersey has no legislation concerning informed consent.

The leading New Jersey case on informed consent is *Kaplan v Haines,* 96 N.J. Super 242, aff'd 52 NJ 404 (1968). In this case, the court held that in order to prevail, the patient-plaintiff using medical expert testimony would have to prove the information given to him significantly was less than the information that the average reasonable practitioner would have disclosed in similar circumstances. The court used a "professional community standard" to define the physician's duty of disclosure.

In the Kaplan case, the court observed that the law does not require a physician to disclose all the details of a proposed procedure or treatment nor all the possible ill effects which conceivably could follow a proposed procedure. Generally, information which a reasonable physician would find significant must be disclosed to the patient. Courts also have recognized that the nature and extent of the required disclosure will depend upon the medical problem as well as the patient. Additionally, to prevail in court, the patient-plaintiff must convince the jury that a reasonable person in the patient's condition would have made an alternative treatment decision had he been fully informed by the physician.

The legal requirements of what constitutes informed consent are defined in New Jersey Model Jury Charge 5.28 (E). In malpractice cases alleging negligent nondisclosure, the judge may instruct the jury: "The doctor's duty is to explain all the facts that a reasonable medical practitioner would explain so that the patient may give his consent with awareness of (1) his existing physical condition, (2) the purposes of, and the advantages of submitting to the operation (procedure), (3) the risks which the operation (procedure) may impose, (4) the risks involved if no operation (procedure) is performed, and (5) the available alternatives and the risks and advantages involved in them."

A troublesome aspect of informed consent is its proof. How should the physician document the fact that he adequately has informed the patient and that the patient has consented? Recent changes in JCAH standards for medical records now require physicians to document evidence of informed consent in the medical record: "A policy on informed consent shall be developed by the medical staff and governing body and shall be consistent with any legal requirements. The medical record shall contain evidence of informed consent for procedures and treatments for which it is required by the policy." (Medical Record Services, Standard II, Interpretation, *Accreditation Manual for Hospitals,* JCAH, 1983.)

Another acceptable and customary method of documentation is the use of informed consent forms signed by the patient. While this method provides some tangible evidence of consent, it is not to be used as a substitute for a full discussion with the patient.

Summary: Under present New Jersey law, the physician's disclosure is measured against what another reasonable practitioner in the same specialty would have disclosed under the same or similar circumstances. The reasonable physician should inform the patient of his existing condition, the proposed treatment or procedure and its risks and benefits, available alternatives and their risks and benefits, and the prognosis if nothing is done.

AVOID LIABILITY IN MELANOMA CASES

Review of melanoma cases, including what experts testify at deposition, provides the following guidelines to assist

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse who are, respectively, Director of the Department and Director of Special Projects.

physicians in preventing or defending a claim from failure to diagnose melanoma.

1. If the patient is concerned about a "mole," remove it by incisional or excisional biopsy (not a shave biopsy which makes tumor thickness measurement and subsequent prognosis estimates impossible) and submit it for pathological examination. This will rule out or confirm the disease for a worried patient. A patient sufficiently concerned to point out and ask about a specific mole indicates sufficient cause to biopsy.

2. If a lesion is pigmented, excision and pathological examination is preferred. These lesions can and do become malignant and invasive during the period of clinical observation, and crucial weeks or months may be lost.

3. If a lesion is not removed, schedule reexamination at a future date. Followup by the physician, rather than reliance on the patient's judgment, is important. Further, if a patient fails to show up for a scheduled followup visit, it is suggested that a certified letter be sent documenting the problem, with a copy to the patient's chart.

4. Records should detail location, size, color, and all descriptive features, particularly of pigmented lesions. Recent literature suggests that lesions be photographed for future comparison on reexamination.

5. Be aware that removal of any lesion without pathological analysis, no matter how benign appearing, becomes difficult to defend if the patient later develops melanoma.

Melanoma diagnosis and treatment is part of a changing field. There are divergent opinions regarding benign moles becoming malignant and spreading melanomas becoming nodular, versus only developing a vertical phase. Periodic review of current literature by the physician is desirable.

In general, excisional biopsy of pigmented lesions with pathological examination is preferred to patient reassurance and continuing observation. *(Norcal Claims Rx,* Vol. 4, No. 2, May-June, 1983.)

MALPRACTICE CRISIS EASING—NOT SO SAY NJ PHYSICIAN INSURERS

Better medical care, inspired by multimillion dollar suits and new laws making it easier to sue, resulted in a sharp decline in medical malpractice claims in the past five years, states a report released by the Rand Corporation, a private, nonprofit institution that engages in nonpartisan research and analysis on problems of national security and the public welfare.

The report, prepared by the think tank's Institute for Civil Justice, is described as the first full-scale analysis of the causes of the 1970s medical malpractice crisis and the consequences of laws passed to ease it. According to the report, "pro-plaintiff" changes in the laws have resulted in more rigorous standards for physicians, thus reducing claims due to negligence.

Robert S. Ritter, president of the California Trial Lawyers Association, said the Rand study simply confirmed what her organization has long contended—"the doctors caused the malpractice."

"The 'knee-jerk' reaction of the California Trial Lawyers Association President is extremely misleading," challenged Peter Sweetland, President of the New Jersey State Medical Underwriters, Inc., the administrative organization for the Medical Inter-Insurance Exchange of New Jersey. "Taken on its own, the remark compares to facetious observations such as, the prime cause of the birth rate seems to be pregnancy, or that consumption of food appears to have some relationship to obesity."

Mr. Sweetland further remarked, "It is true that the study does imply a major factor in the number of professional liability claims and suits are due to professional negligence, however, to limit any conclusions to that observation alone totally is misleading. The fact still exists that more medical professional liability actions are unsuccessful than in any other field that I know of.

"While I do not necessarily agree that there are significant errors in the data used in the study, there is a major weakness in the fact that the information cuts off in 1978. There is little argument that the number of claims and suits asserted dropped off in 1976 and 1977. The Institute failed to observe that most suits saw a resurgence by 1979 and 1980. Most companies would agree today that the gradual increase in frequency has resumed back at the pace which existed prior to 1975. Whether or not the hiatus noted in the study is truly the result of legislative change or more careful doctor attitudes will be debated for some time. I personally believe all of the attention devoted to the malpractice crises in 1975 and 1976 suppressed lawyer activity for awhile. The pace of social influence abated and the combined result was a short period of lessened activity and less doctor payments.

"Today it looks to us as though there is a resurgence of local activity and an increase in the expectations of the public. Unfortunately, this was not noted in the Institute's study as they cut the information off too soon. Specifically, I also would argue that the legislative change has not had as great an effect as they might surmise. Everyone will recall that in New Jersey we did not adopt the same changes that occurred in California and other states described in the study, yet we also encountered the same turn-down shown elsewhere.

"If I have one overall conclusion about the study, I believe it is a fine start, but heavily underlines the need for a cooperative data-gathering effort among doctor and hospital-owned companies to fill in the next episode."

Paul H. Mathewson, Underwriting and Marketing Manager of Health Care Insurance Exchange, also sees errors in the Rand Report stating that, "Since many insurance carriers switched to claims-made coverage in 1975 and 1976, the study may not accurately reflect claims that were reported subsequent to 1975 that occurred earlier. The report also failed to consider the establishment in the mid-1970s of 'Bed Pan' Mutuals, which, for the most part, placed greater emphasis on loss prevention and risk management than did commercial insurers.

"It is my opinion that the study does not accurately reflect today's malpractice climate. HCIE has experienced a 25 percent increase in the number of new claims during 1982 and this trend is expected to continue during 1983."



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next page for summary of product information.

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warning: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly and debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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Complications of Diabetes

Complications of diabetes are major threats to the patient with that disorder—even before the diagnosis is established. For example, diabetic ketoacidosis heralds the onset of type I diabetes in far too many persons. Unfortunately, the morbidity and mortality from diabetes is largely dependent on such complications and insulin has not alleviated them. Indeed, insulin has increased the incidence and prevalence of complications by permitting diabetics to survive long enough to develop the microangiopathic diseases of the retina, kidney, and other tissues, which were rare in the preinsulin era.

The National Diabetes Advisory Board, a prestigious nonofficial body of scientists, health professionals, and nonprofessionals with knowledge and interest in the subject, acted in June 1980 "to develop recommendations that might reduce mortality and morbidity from diabetes." They convened at Airlie, Virginia, with the participation of specialists, primary care practitioners, scientific experts, and consultants from the National Institutes of Health and numerous universities.

The conference focused on the major complications of diabetes:

- Detection and prevention of visual impairment.
- Detection and prevention of adverse outcomes in pregnancy.
- Detection and prevention of foot problems.
- Detection and prevention of kidney problems.
- Detection and prevention of acute hyperglycemia and ketoacidosis.

The fruit of three years of labor and extensive field testing in New Jersey and other states was a publication called, "The Prevention and Treatment of Five Complications of Diabetes." The publication was designed to bridge the knowledge gap between the research worker and the provider of health care services. Thus, the booklet not only includes a synopsis of the best current methods to prevent and detect the complications, but also contains patient education materials, office guides, reading lists, and a current classification of diabetes.

All primary care physicians can benefit from these materials, which are available through the New Jersey State Department of Health Demonstration Diabetes Control Project (Division of Community Health Services, CN 364, Trenton, NJ 08625), a program sponsored by the National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases, and by the Chronic Disease Center, Atlanta. These guides can be used for medical staff conferences, for allied professional in-service training, and for individual self-instruction.

Avail yourself of this opportunity to "pick the brains" of the experts and use the information to enhance the care of your patients with diabetes of all ages. A.K.

Publication Awards for MSNJ Auxiliary

The Medical Society of New Jersey Auxiliary was the recipient of three recognition awards for its publication, *The Shingle,* at the 1983 AMA Auxiliary Convention in Chicago. The awards included "Most Improved Publication" and "Most Outstanding Auxiliary Publication in the Country."

Awards were judged on the basis of subject matter, originality, style, writing quality, readability, use of graphics, visual appeal, and organization. The judges were selected from among editors, writers, and graphic artists within the Chicago area. There were 102 entries in three categories including 21 state publications.

Shirley Walsh
Executive Secretary, MSNJ Auxiliary

Somerset County Medical Society Donation

In recognition of the Medical Society of New Jersey's efforts on behalf of the profession, Doctor Albert M. Doswald, President of Somerset County Medical Society, announced that his county is donating $2,000 to be used for general activities of the Society.

Upon motion by Doctor Slobodien, seconded by Doctor Schauer, and carried, a letter was sent, expressing the Board of Trustee's appreciation for the contribution.

Credentials Committee

In the past decade, courts have ruled that hospitals may be held liable for the harm suffered by patients when it has been shown that the harm is traceable to the hospital's failure to review and monitor adequately the qualifications and performances of medical staff members. It is clear that hospitals owe a legal duty to patients to exercise reasonable care in the selection of the medical staff. This legal duty arises out of the obligation of the hospital governing board to exercise its discretionary powers for the benefit of the public.

Final authority for granting or denying appointments to the medical staffs of hospitals resides in the hospital's governing board. However, governing boards commonly delegate the responsibility of investigating and evaluating an applicant's qualifications for clinical privileges to the medical staff, in particular, to the credentials committee of the medical staff.

Courts have reviewed medical staff committee failure to investigate adequately the qualifications of applicants to the medical staff as giving rise to a foreseeable risk of harm to the patient. The opinions of courts which have considered litigation in this area contain a host of suggestions as to the appropriate scope of the credential review process.

In the case of *Johnson v Misericordia Hospital,* 301 N.W. 156 (1981), the Supreme Court of Wisconsin held that a medical staff investigating committee at a minimum should require completion of an application and verification of the accuracy of the applicant's statements, especially in regard to medical education, training, and experience.

The court also ruled: "Additionally, it should (1) solicit information from the applicant's peers, including those not referenced in his application, who are knowledgeable about his education, training, experience, health, competence, and ethical character; (2) determine if the applicant currently is licensed to practice in this state and if licensure or registration has been or is being currently challenged; and (3) inquire whether the applicant has been involved in any adverse malpractice action and whether he has experienced a loss of medical organization membership or medical privileges or membership at any other hospital. The investigating committee also must evaluate the information gained through its inquiries and make a reasonable judgment as to the approval or denial of each application for staff privileges."

It is obvious that the decisions of the medical staff credentials committee nearly always are limited to a consideration of material submitted in response to questions contained in the application form. For this reason, members of the credentials committee may be wise to perform an assessment of the adequacy of their application form. In addition to the requirements as outlined by the Wisconsin Supreme Court, it is appropriate to question an applicant regarding the details of his malpractice insurance history and to request the names of present and past insurance carriers, policy numbers, and dates of coverage. It also is appropriate to ask whether the applicant ever has been the subject of any administrative, civil, or criminal proceeding as well as requesting the dates, circumstances, and ultimate disposition of each such event.

Some hospitals reasonably ask applicants to authorize the hospital to contact any agency, authority, hospital, physician, or other party who may provide information relevant to the application or privileges requested. It also is appropriate to ask applicants to acknowledge that the material contained in the application is true and that a failure to respond to any question or any knowingly false statement may constitute grounds for denial of the application.

Medical staff leaders should consult the *Accreditation Manual for Hospitals* of the Joint Commission on Accreditation of Hospitals for further guidelines in this area of increasing judicial scrutiny.

One of the most difficult problem areas in the process is to obtain truthful recommendations about applications from other hospitals or physicians with whom they have worked. These parties usually are willing to be verbally frank but are invariably reluctant to put it in writing out of fear of being sued for defamation of character or tortious interference with some prospective or anticipated business relationship, among other legal theories.

There is no easy solution to this problem. Even though the hospital staff application may have some "hold harmless" clause for statements made in good faith, credential references know that no clause can prevent them from being sued in the first place. This exposes the reference giver to the risk of losing time, gaining aggravation, and incurring the cost of legal defense. All of this constitutes a considerable hurdle to overcome in the credential process because people generally are not willing to assume these risks associated with giving a negative, written reference for a medical staff applicant. Until this hurdle is removed, denial of privileges will continue to be a risky business for the credentials committee and the hospital. J.E.G.

*The material for this column is coedited by Arthur Krosnick, M.D., Editor, *The Journal;* Vincent A. Maressa, Executive Director, MSNJ; and James E. George, M.D., J.D., Director of the Department of Professional Liability.

SPECIAL COMMENTARY

In Search of Excellence: JCAH Medical Staff Standards

JAMES S. TODD, M.D., Ridgewood*

The process of revising the medical staff chapter of the Joint Commission on Accreditation of Hospitals' (JCAH) *Accreditation Manual for Hospitals* began in 1981 and continues. The draft proposal now is undergoing a fourth field review. Comments will be reviewed by the JCAH Standards-Survey Procedures Committee in November. The JCAH Board of Commissioners will take final action on the medical staff chapter on December 10, 1983.

The process of revising the medical staff chapter of the Joint Commission on Accreditation of Hospitals' (JCAH) *Accreditation Manual for Hospitals* continues. It began in 1981 as an effort to make the standards more flexible for and adaptable to individual hospitals and their medical staffs. It became an arena for controversy.

At its meeting in mid-August, the JCAH Board of Commissioners approved the AMA's request for a field review of the latest draft of the medical staff chapter. As a result, a draft was sent, for the fourth time, to more than 3,000 individuals and organizations for review and comment.

Throughout the revision process, the JCAH Board of Commissioners and its corporate member organizations have struggled to resolve a few basic issues—maintenance of quality care in the nation's hospitals, removal of provisions that have been interpreted as denying entire categories of limited licensed practitioners access to medical staff membership, and clarification of privilege delineation.

Those issues have stirred much debate throughout the medical profession. The debate has been constructive. It raised questions about the overall responsibility for the medical care of patients, about the importance of the delineation of clinical privileges, and about the very composition of the "medical staff."

The current draft represents sincere discussion and willingness on the parts of all five of the corporate member organizations of the JCAH to respond to the concerns expressed by their various constituencies.

At its 1983 Annual Meeting, the AMA House of Delegates adopted Substitute Resolution 116, which not only directed the AMA Commissioners to the JCAH to request this fourth review, but affirmed six principles as the basis for any revisions in the medical staff chapter of the *Accreditation Manual for Hospitals*.

Before attempting to compare directly the AMA's principles with specific standards in the current draft, it must be said that the chapter's provisions are inextricably woven together to create the whole. Individual items taken out of context can lead to misunderstanding. In particular, Standard I (the medical staff as an organization) and Standard IV (delineation of clinical privileges), taken together, clearly

*Dr. Todd is a Trustee, American Medical Association and Commissioner to the JCAH.

define individuals who are eligible for medical staff membership, the requirements for the delineation of clinical privileges, who may be granted the privilege to admit and treat patients in the hospital, where the responsibility for the general medical condition of each patient lies, and which medical staff members may perform histories and physical examinations.

Put simply, these two standards address the basic issues. They deal with both the quality of care delivered in the hospital and with the recognition of the legal rights of qualified limited licensed practitioners to pursue their professions.

The AMA Commissioners to JCAH have worked diligently to revise the current draft to comply with the six principles adopted by the House of Delegates, and it is our belief that the provisions of the new draft substantially accomplish this goal.

First, all references in the title of the chapter and throughout the manual are to the "medical staff."

Secondly, the AMA House of Delegates requested that specific references to limited licensed practitioners contained in the current manual, which defines the "medical staff" as fully licensed physicians and licensed dentists, be deleted. This has been accomplished in the definition of the medical staff in Standard I, Required Characteristic A.1. in the draft. The only remaining specific references are contained in Standard IV (delineation of clinical privileges), Required Characteristics C.1. and C.2., which deal with qualifications placed on privileges to perform histories and physical examinations granted to nonphysician licensed practitioners.

In accordance with the second AMA principle, other provisions in Standard IV would permit limited licensed practitioners to have hospital privileges consonant with their training, experience, and current competence, if approved by the normal credentialing process.

The third AMA principle seeks to provide consideration of qualified limited licensed practitioners in accordance with state law and when approved by the executive committee of the medical staff and by the governing board and when their services are appropriate to the goals and missions of that hospital, taking into account their training, experience, and current competence.

Standard I in the draft describes the definition, organization, and appointment mechanisms for the medical staff. It says that the medical staff "includes fully licensed physicians and may include other licensed individuals permitted by law and by the hospital to provide patient care services independently in the hospital."

Clarification of the term, "individuals permitted to provide patient care services independently," is provided by a glossary definition appearing on the same page as the standard. It reads, "Any individual who is permitted by law and who also is permitted by the hospital to provide patient care services without direction or supervision, within the scope of the license and in accordance with individually granted clinical privileges. Clinical privileges are based upon criteria established by the hospital."

The composition of the medical staff, as defined in Standard I, has been of great concern to physicians. However, the definition attempts to address that concern. Only physicians (M.D.s and D.O.s) are required to be on the medical staff. Other licensed individuals may be included, at the hospital's option, and then only if they are permitted both by law and by the hospital to provide patient care services without direction or supervision. The services an individual would be permitted to provide in a given institution would be defined through the delineation of his individual clinical privileges. The bases for granting privileges are outlined in Standard IV.

Standard I, Required Characteristic B states that appointment to the medical staff is made through a hospital-specific mechanism that is approved and implemented by the medical staff and the governing body.

The fourth AMA principle would have the standards provide that the medical staff executive committee is composed of a majority of physicians. Standard III, Required Characteristic E.1. states, "All members of the medical staff are eligible for membership on the executive committee, but a majority of the executive committee members are fully licensed physician members of the medical staff actively practicing in the hospital."

AMA principle five seeks to assure that the medical care of all patients remains under the supervision and direction of qualified, fully licensed physicians (M.D.s and D.O.s). This principle most clearly is articulated in the draft in Standard IV, Required Characteristic C.4., which states, "Each patient's general medical condition is the responsibility of a qualified physician member of the medical staff." A "qualified physician" is defined as "a doctor of medicine or doctor of osteopathy who, by virtue of privileges granted by the hospital, is permitted to perform a specific diagnostic or therapeutic procedure." Other requirements in Standard IV provide for a prompt medical evaluation by a qualified physician for patients admitted by nonphysician members of the medical staff who have admission privileges, and for the performance and/or confirmation of a history and physical examination by a physician on such patients.

The sixth AMA principle seeks to assure that the continued high quality of care, credentialing of physicians and other licensed practitioners, and effective quality assurance programs remain under the supervision and direction of fully licensed physicians. Standards IV, V, and VI assign to the medical staff the implementation of the process for the delineation of clinical privileges, the implementation of the process for reappointment and reappraisal of clinical privileges, and involvement in the hospital's quality assurance program. These Standards, in combination with the required majority of physician membership on the medical staff's executive committee, comply with the provisions set forth in principle six.

The process of revising the medical staff chapter continues. The JCAH Standards-Survey Procedures Committee will review the comments received from the field at its November meeting and make a recommendation to the Board of Commissioners. The Board is scheduled to take final action on the medical staff chapter at its December 10 meeting.

Whatever action the Board of Commissioners takes, the medical staff standards, along with the entire *Accreditation Manual for Hospitals,* will undergo continuous review and refinement.

The medical staff chapter, as circulated in the fourth field review, represents a cooperative effort on the part of the Board of Commissioners. The AMA Commissioners believe it is our best effort yet to address the issues with which we have been confronted, and which we will continue to assess.

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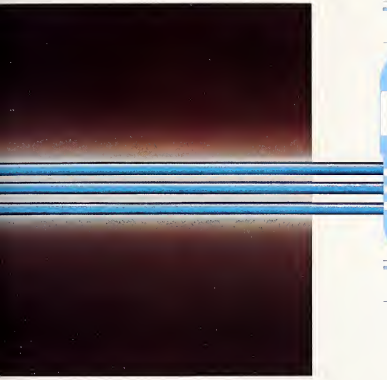
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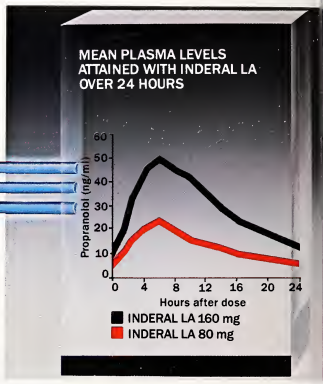
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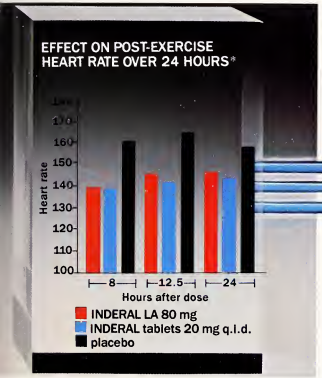
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Provides therapeutic benefit throughout the day and night

In placebo-controlled trials, INDERAL LA was found to provide sustained 24-hour beta blockade as measured by decrease in heart rate, systolic blood pressure, and rate-pressure product. Patients taking once-daily INDERAL LA receive continuous protection from dose to dose–with therapeutic response equivalent to multiple daily doses of INDERAL tablets.

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*INDERAL LA vs. tablets: N.S. at all hours measured.
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THE ONE TO COUNT ON FOR INITIAL THERAPY IN HYPERTENSION

Start with 80 mg once daily

The usual initial dose is 80 mg INDERAL LA whether used alone or with a diuretic. Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control.

When converting patients from other beta blockers including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary.

Unsurpassed convenience and simplicity

Enhanced patient compliance



THE ONE TO COUNT ON

AND ANGINA

Simplified core therapy begins with 80 mg once daily

Although individual patients may respond to various doses, the average optimal dose in angina pectoris is 160 mg once daily.

Compatible with other conventional antianginal therapies

The experience and protection of INDERAL

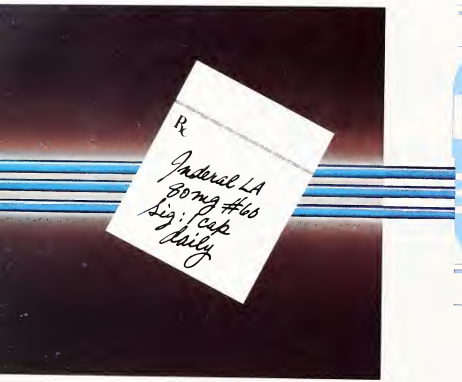
Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

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In hypertension, angina, and migraine—start with 80 mg once daily

Smooth 24-hour control

Unsurpassed simplicity and convenience

Enhanced patient compliance

Three strengths for prescribing convenience

For arrhythmias, use conventional INDERAL® tablets

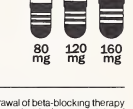
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EF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

DERAL® brand of propranolol hydrochloride

) mg, 120 mg, 160 mg Long Acting Capsules)

ESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol rochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

INICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes h beta-adrenergic receptor stimulating agents for available receptor sites. When access to e receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator sponses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled d predictable rate. Peak blood levels following dosing with INDERAL LA occur at about hours and the apparent plasma half-life is about 10 hours. When measured at steady state r a 24-hour period the areas under the propranolol plasma concentration-time curve (UCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable ded daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater patic metabolism of propranolol, resulting from the slower rate of absorption of propranolol e to receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator sponses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA should not be considered a simple mg for mg substitute for conventional ngue tablets, and the blood levels achieved do not match (are lower than) those of two to four es daily dosing with the same dose. When changing to INDERAL LA from conventional opranolol, a possible need for retitration upwards should be considered especially to intain effectiveness at the end of the dosing interval. In most clinical settings, however, ch as hypertension or angina where there is little correlation between plasma levels and nical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of nventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour ercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. ong the factors that may be involved in contributing to the antihypertensive action are) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminuon of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total eripheral resistance may increase initially, it readjusts to or below the pretreatment level with ronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL s been shown to cause a small increase in serum potassium concentration when used in e treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart any given level of effort by blocking the catecholamine-induced increases in the heart rate, ioelectric stimulation, and the velocity and force of myocardial contraction. Propranolol ay increase oxygen requirements by increasing left ventricular fiber length, end diastolic ressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade ften is decreased cardiac work and is manifested during exercise by delayed onset of pain and creased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine- or anesthetic-like membrane action which affects the cardiac action potential. The gnificance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. eta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta blockade can be carried into the fetus and newborn. In the presence of physiologic or nctional changes, sympathetic activity is detrimental to the patient. But there are also tuations in which sympathetic stimulation is vital. For example, in patients with severely arrowed AV conduction, adequate ventricular rate may be dependent upon sympathetic drive hich should be preserved. In the presence of AV block, greater than first degree, beta lockade may prevent the necessary facilitating effect of sympathetic activity on conduction eta blockade results in bronchial constriction by interfering with endogenous bronchodilator ctivity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive gents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of ypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for he long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for prophylaxis of common migraine headache. he efficacy of propranolol in the treatment of a migraine attack that has started has not been stablished and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of ypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced ngina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of he elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. linical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in (1) cardiogenic shock; 2) sinus radycardia and heart block greater than first degree; (3) bronchial asthma; 4) congestive heart ailure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by eta blockade may precipitate more severe failure. Although beta blockers should be voided in overtly congestive heart failure, if necessary they can be used with close follow-up n patients with a history of failure who are well compensated and are receiving digitalis and iuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on eart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta lockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of mpending failure, INDERAL should be withdrawn (gradually if possible) and the response bserved closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstate INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema): PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be carefully observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. Usable evidence of safety from adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular System. Bradycardia; congestive heart failure, intensification of AV block; hypotension, paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type

Central Nervous System. Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory bronchospasm.

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serosa, mesentery and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained release capsule for administration once daily If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Therefore, it may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval

HYPERTENSION – *Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of 640 mg may be required The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS – *Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE – *Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within the first six to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS – 80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Ayerst AYERST LABORATORIES
New York, N.Y. 10017

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

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Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral

Methyltestosterone U.S.P. Tablets

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Fluoxymesterone U.S.P. Tablets, 10 mg.





Improved Echocardiographic Visualization in Emphysematous Subjects

JERALD L. COHEN, M.D., KHAWAJA N. ANWAR, M.D.,
ROGER DAY, M.A., East Orange*

It is difficult to obtain satisfactory M-mode echocardiograms in patients with emphysema. We studied ten patients in the supine, sitting, and standing position, with the transducer in the standard intercostal and subxiphoid locations. Our results revealed enhanced visualization of the mitral valve, tricuspid valve, right ventricle, interventricular septum, left ventricle, and left ventricular posterior wall when recorded from the sitting or standing position with the subxiphoid transducer location. We recommend this technique for this study in patients with emphysema.

The difficulty of obtaining satisfactory M-mode echocardiograms in patients with emphysema is well known. The increased antero-posterior diameter of the thorax and hyperinflated lung interposed between transducer and heart result in poor quality ultrasonic images. The introduction of the subxiphoid transducer position represented an improvement over the standard intercostal transducer position in recording echocardiograms from these subjects.[1] In our laboratory, we observed that the quality of the echocardiographic images in these subjects was enhanced even further by recording the tracings with the patients in the sitting or standing positions.

METHODS

Ten consecutive male patients (mean age 61 years), with a diagnosis of severe emphysema based on clinical and pulmonary function testing criteria ($FEV_1/FVC < 45$ percent), were systematically studied to compare the quality of M-mode echocardiographic images from the sitting or standing positions with standard supine and subxiphoid echocardiograms. All patients had increased antero-posterior chest diameters and depressed diaphragms. M-mode tracings were recorded using an Irex System II echocardiograph with a 2.25 or 1.6 Hz transducer. Tracings were recorded with the transducer in both the standard position (fourth or fifth intercostal space just to the left of the sternum) and in the subxiphoid position and with the patient supine, sitting, and standing. There were therefore six transducer positions: 1 = supine-intercostal; 2 = supine-subxiphoid; 3 = sitting-intercostal; 4 = sitting-subxiphoid; 5 = standing-intercostal; and, 6 = standing-subxiphoid.

Echocardiographic images were reviewed independently by two observers without knowledge of transducer position. A grading system based on echocardiographic quality (clarity score) was used to evaluate each of the following structures: right ventricular chamber, interventricular septum, left ventricular chamber, left ventricular posterior wall, mitral and tricuspid valves, aortic valve, and root.

Each structure was graded on a scale of 0 to 3: 0 = structure not visualized; 1 = fair; 2 = good; and, 3 = excellent. Criteria for evaluating chambers and wall thicknesses included visualization of one or both limiting surfaces (endocardial or pericardial) and for evaluating valvular structures, one or both leaflets. A score of 1 was assigned if one limiting border or surface of a wall or chamber was visualized or one leaflet of a valve. A score of 2 was assigned

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TABLE 1

Average Clarity Score for Six Transducer Positions on Each Structure in Ten Emphysematous Subjects

Structure	Transducer Position 1	2	3	4	5	6	Transducer Position (1-6) Rank Order
AO	1.4	0.7	1.1	0.8	0.3	0.65	134265
AV	0.75	0.6	0.6	0.3	0.2	0.1	1(23)456
RV	0.85	1.5	1.6	2.15	0.55	2.35	643215
TV	0.1	0.9	0.15	1.1	0	0.9	4(26)315
MV	0.65	0.85	0.95	1.55	0.55	1.2	463215
IVS	0.6	1.75	1.65	2.35	0.65	2.55	642351
LV	0.45	1.35	1.3	1.65	0.35	1.65	(46)2315
LVPW	0.35	1.2	1.0	1.5	0.45	1.25	462351

Transducer position numbering corresponds to that mentioned in text. Clarity scores: 0 = absent, 1 = fair, 2 = good, 3 = excellent. Rank order of transducer positions arranged with position of highest score to the left. AO = Aortic root; AV = Aortic valve; IVS = Interventricular septum; LV = Left ventricular cavity; LVPW = Left ventricular posterior wall; MV = Mitral valve; RV = right ventricular cavity; TV = Tricuspid valve.

TABLE 2

Cardiac Dimensions Obtained from Four Transducer Positions

	RVD(cm)				IVS(cm)				LVD(cm)				LVPW(cm)			
Transducer Position	**1**	**2**	**4**	**6**	**1**	**2**	**4**	**6**	**1**	**2**	**4**	**6**	**1**	**2**	**4**	**6**
Patient No.																
1	–	1.6	2.0	2.6	–	0.9	1.3	1.0	–	–	5.0	4.4	–	–	1.1	1.2
3	–	2.6	2.0	2.2	–	0.9	1.0	1.0	–	5.0	4.6	4.3	–	1.0	1.0	1.0
4	3.1	3.3	3.1	3.0	0.9	1.2	1.1	1.0	–	4.6	4.6	4.5	–	1.2	1.2	1.2
7	3.5	3.5	4.0	3.7	1.2	1.1	1.0	1.1	–	4.6	–	4.5	1.3	1.3	1.0	1.2
10	–	2.1	2.1	2.0	–	0.9	0.9	1.0	–	4.8	4.5	4.3	–	0.9	1.2	1.1
2	–	–	1.8	1.8	–	–	1.0	0.9	–	–	4.6	4.3	–	–	1.0	1.1
5	–	2.8	2.7	2.6	–	–	1.0	1.0	–	–	4.4	4.3	–	–	1.0	1.0
6	–	2.7	2.7	3.0	–	–	1.0	0.9	–	–	4.5	4.3	–	–	1.0	1.0
8	–	–	2.7	2.9	–	–	1.0	1.1	–	–	5.0	4.8	–	–	1.1	–
9	–	–	2.6	2.5	–	0.9	0.9	1.0	4.4	–	4.3	4.5	1.0	–	1.0	1.0

Dashes indicate images not considered clear enough to make a measurement possible. Transducer position numbers correspond to those in text. IVS=Interventricular septal thickness; LVD=Left ventricular dimension at end-diastole; LVPW= Left ventricular posterior wall thickness; RVD=Right ventricular dimension at end-diastole.

if both limiting surfaces or leaflets were seen. A score of 3 was assigned if the complete structure or valve was seen unusually well, as might be seen in a high-quality echo of a nonemphysematous, healthy adult.

The average clarity scores of each structure from the ten patients using each transducer position were statistically compared to determine the relative performance of each transducer position. Comparisons between two imaging methods, say A and B, were made by calculating for each patient the number of structures for which A provided greater ranging to B; the signed rank test was then applied to these scores.[3] Inspection of the ranking orders (Table 1) showed that the structures segregated into two groups, aortic and nonaortic structures. Because an anatomic basis for this is possible, the two groups were analyzed separately. Bonferroni adjustment was made for all P values where appropriate.[3]

RESULTS

Illustrative echocardiograms are shown in Figures 1 and 2. Figure 1A, an image of the left ventricle recorded from the sitting-subxiphoid position, shows enhanced clarity of structures and less echo noise than the corresponding image from the same patient (Figure 1B) obtained from the supine-subxiphoid position. Similar improvement of the sitting-subxiphoid over the supine-subxiphoid position is shown for the mitral valve in Figures 2A and 2B.

Table 1 shows the average clarity scores of the ten patients in each of the six transducer positions. As expected, the overall level of scores in these subjects was relatively low, confirming the difficulty of recording echocardiograms from emphysematous subjects. However, definite and significant improvements in image quality were found with the sitting or standing posture when combined with the subxiphoid transducer position over either the supine-intercostal or supine-subxiphoid transducer positions.

Statistical comparisons of the echocardiographic clarity scores of nonaortic structures were as follows: position 6 (standing-subxiphoid) performed better than position 2 (supine-subxiphoid), $P = .02$, while position 4 (sitting-subxiphoid) performed better than position 2 (supine-subxiphoid), $P = .03$. Position 4 (sitting-subxiphoid) performed

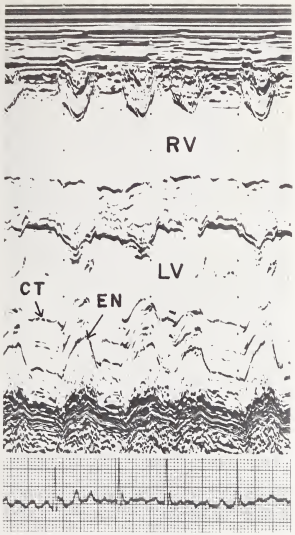


Figure 1A—Sitting-subxiphoid view (transducer position 4) of the left ventricle. There is enhanced echocardiographic clarity with distinct visualization of endocardial margins of right ventricle, interventricular septum, and left ventricular posterior wall from the supine-subxiphoid position (Figure 1B). Clarity score = 3. CT = Chorda tendinae; EN = Endocardium; LV = Left ventricle; RV = Right ventricle.

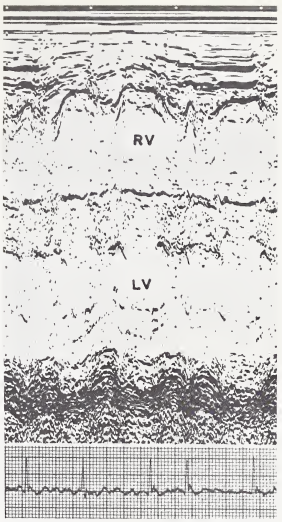


Figure 1B—Supine-subxiphoid view (transducer position 2) of left ventricle from same patient as Figure 1A. Endocardial margins are less distinct and there is more echo noise. Clarity score = 1.

better than position 1 (supine-intercostal), $P = .03$. Positions 6 and 2 performed better than position 1, but the comparisons did not meet the strict Bonferroni criterion. In addition, no statistically significant improvement was noted for the sitting or standing intercostal transducer locations. No comparison was significant among the aortic structures (aortic valve and root) because imaging was equally good among all transducer positions.

Linear measurements at end-diastole of right and left ventricular dimensions, interventricular septal wall and left ventricular posterior wall thicknesses in the ten patients (made from a total of 40 images) were possible mainly in the sitting- or standing-subxiphoid positions. Out of 40 images using the supine-intercostal position, only 7 images were clear enough for measurement; 21 out of 40 images were clear enough using the supine-subxiphoid position. However, 39 out of 40 images were clear enough for measurement for each of the sitting- and standing-subxiphoid positions.

Measurements made of right and left ventricular dimensions, interventricular septal, and posterior wall thickness were compared among the transducer positions using an analysis of variance (Table 2). For the right ventricular dimension, any of the transducer positions could discriminate among the patients ($P < .001$). Transducer positions could discriminate among the patients for left ventricular posterior wall thickness ($P = .05$), but with less statistical force. For interventricular septum, the variation was not significant and could have been due to random error. For left ventricular dimension, at end-diastole, variation due to transducer position was marginally significant ($P = .05$).

DISCUSSION

These results indicate that for the purpose of imaging nonaortic structures, a sitting or standing position combined with a subxiphoid transducer location usually will provide the clearest image. The use of the upright posture in recording echocardiograms from emphysematous subjects has not been reported previously.

It generally is believed that the subxiphoid transducer position offers an advantage over the intercostal approach in emphysematous subjects because of the elimination of hyperinflated lung interposed between transducer and heart.[1] The results of our study indicate further refinement in echocardiographic clarity if the sitting or standing position is combined with the subxiphoid approach. This additional improvement may be due to an even closer proximity of heart and transducer in these subjects with depressed diaphragms. Diaphragms may be depressed further with the erect posture, bringing the heart closer to the transducer.

On the basis of these observations, we have modified the standard echocardiographic technique for studying emphysematous patients. With a subxiphoid transducer location, we first scan the patient in the sitting or standing position in order to avoid fatigue if this is done at the end of the examination. The examination then is completed in the usual supine positions.

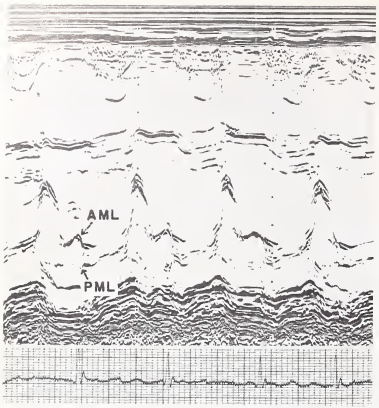


Figure 2A—Sitting-subxiphoid view (transducer position 4) of mitral valve. Echo noise is absent, and both anterior and posterior mitral leaflets are clearly visualized. Clarity score = 3. AML = Anterior mitral leaflet; PML = Posterior mitral leaflet.

Chang and Feigenbaum,[1] in their study of emphysematous patients, found agreement between the intercostal and subxiphoid transducer positions for the measurements of left ventricular dimension, but not for right ventricular dimension. Our study showed agreement among measurements made in the various transducer positions for right ventricular dimension and left ventricular wall thickness, but there was some marginal variability in measurements made of left ventricular dimension. Some of this variability could have been introduced by the changes in posture employed in this study. However, we do not know what the true "gold standard" for left ventricular dimensions is in the emphysematous patient. With the heart in the more vertical position due to lowered diaphragms, the standard supine transducer positions may not necessarily be accurate. Based on our data, we cannot conclude which transducer position offers the most accurate linear measurements. Further studies using ventricular volume determinations derived from either cineangiography or radionuclide techniques would be necessary to fully evaluate the accuracy of linear measurements in emphysematous subjects obtained by echocardiography in various transducer positions. In conclusion, the addition of the sitting or standing posture to the subxiphoid transducer location, enhances the quality of echocardiographic images obtained from patients who technically have been difficult to study.

SUMMARY

We have observed that the quality of M-mode echocardiograms obtained from patients with severe emphysema is improved if recorded with the patient sitting or standing. In this study, ten consecutive patients with emphysema were studied with M-mode echocardiography to compare the quality of echocardiographic images from the supine, sitting, and standing positions, with the ultrasound transducer in the standard intercostal and subxiphoid locations.

Echocardiographic images were graded qualitatively and compared statistically for all the cardiac structures analyzed from each of the transducer locations. Visualization of the mitral valve, tricuspid valve, right ventricle, interventricular septum, left ventricle, and left ventricular posterior wall were enhanced when recorded from the sitting or standing position combined with the subxiphoid transducer location. Echo quality grades were better statistically for the sitting- or standing-subxiphoid positions compared to the supine-subxiphoid position ($P = .03$, $P = .02$, respectively). Because of the enhanced echo clarity in the upright posture, more complete measurements of echocardiographic dimensions were possible using the new transducer locations.

Thus, enhanced echocardiographic images can be obtained in these difficult subjects if the recording protocol includes the sitting or standing positions.

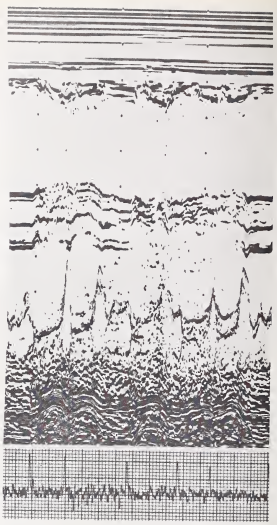


Figure 2B—Supine-subxiphoid view (transducer position 2) of mitral valve from same patient as Figure 2A. Only the anterior mitral leaflet is visualized and there is considerable echo noise. Clarity score = 1.

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The Blue Shield of New Jersey Second Surgical Opinion Program

CHARLES L. CUNNIFF, M.D., Newark*

Blue Shield of New Jersey initiated a voluntary second surgical opinion program in 1977. The results are similar to other voluntary programs, i.e. the utilization has been low. Approximately two-thirds of the consultations confirmed a need for recommended surgery. Nonconfirmed, however, is not to be equated with unnecessary; many second opinions appear to reflect reasonable differences of opinion about indications for, and/or timing of surgery.

Programs for second opinions on elective surgery that have been developed by a number of insurers are aimed at potential cost-containment by identifying and reducing unnecessary surgery. The programs give patients an opportunity to make a better-informed decision, and hope to maintain a reasonable quality of care.

Interest in the concept grew out of the work by McCarthy and Widmer in New York in the early 1970s.[1] Some of their results were subjected to extensive statistical manipulations which suggested that there were millions of unnecessary operations and thousands of unnecessary deaths in the United States every year. This occurred despite the fact that McCarthy warned that the findings of his mandatory program could not be extrapolated to the general population.

Second opinion programs for elective surgery are of three types: mandatory—for which no benefits will be paid if a consultation is not obtained; voluntary—consultation optional, and surgical benefits paid regardless of whether consultation is obtained and regardless of the consultant's opinion; and incentive—consultation optional, but the level of benefits will be lower if consultation is not obtained.

Programs may cover large numbers of unspecified procedures or may be restricted to certain high volume discretionary procedures that clearly justify additional opinion.

BLUE SHIELD OF NEW JERSEY PROGRAM

Blue Shield of New Jersey originally developed a voluntary second surgical opinion program effective March, 1977, on a pilot program basis. As a result of subsequent legislation, this later became a permanent benefit for all groups of 100 or less subscribers and all direct enrollees. It also is available to all larger groups that want the benefit. Currently, approximately 2½ million persons are covered for second surgical opinion.

Program Design. The program allows a subscriber whose physician recommends an elective, inpatient surgical procedure to seek a second opinion by calling (toll-free) the Blue Shield Second Opinion Referral Center. The Referral Center furnishes the names of three cooperating board certified specialists in the appropriate specialty, located conveniently for the subscriber, who then makes an appointment with the consultant of his or her choice. The Plan pays for the consultation and any necessary diagnostic studies, as well as for a voluntary third opinion should the second opinion consultant recommend against the proposed surgery.

A consultation obtained other than through the Referral Center is not eligible for reimbursement.

The program is entirely voluntary; there are no conditions on eligibility of payment for any surgery dependent either on obtaining a second opinion or on the result of the second opinion consultation.

Subscriber Participation. By September 1982, approximately 3,600 consultation reports have been received. This amounts to less than 1 percent of all elective inpatient surgery among subscribers who had the benefit available, and obviously represents low use of the benefit.

Consultants. To establish a panel of consultants, Blue Shield solicited all physicians in New Jersey and nearby counties of neighboring states who were board certified in general surgery and surgical specialties. As a result of subsequent legislation, board certified medical specialists

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also were included. About 2,000 consultants have signed cooperating physician agreements.

Cooperating consultants agree to accept plan payment for the consultation and any necessary diagnostic studies as payment in full. They also agree not to perform the surgery.

Results. In general, data are comparable to other voluntary second opinion programs: about two-thirds of the people for whom arrangements are made actually obtain second opinions; of those who receive second opinions, about 65 percent receive opinions which confirm current need for the recommended procedure; and the remainder get recommendations classified as nonconfirmed.

In comparison, mandatory programs (in which all patients must obtain a second opinion or the insurance will not pay for the treatment) show significantly lower nonconfirmation rates, ranging from 5 to 20 percent.[2] This can be expected, since those who obtain voluntary consultations are a self-selected group.

The most common procedures for which second opinions have been requested are shown in Table 1.

Nonconfirmation varies from procedure to procedure. Blue Shield of New Jersey data shown in Table 2 are compared to information extracted from an article by McCarthy which reports experience with a mandatory program in New York City.[3]

Nonconfirmation is not to be equated with unnecessary. Our consultants rarely say that the contemplated surgery is not indicated at all—but they make suggestions for somewhat different care, including further observation, trial of alternative management, or more diagnostic information, as summarized in Table 3.

Somewhat disturbing is the small but significant percentage classified as "no pathology." These reports have been reviewed carefully and classification verified.

In line with other reports, most (at least 80 percent) of those classified as nonconfirmed did not have the surgery. In a two-year followup study of the pilot program, 165 nonconfirmed did not have surgery. This was 85.5 percent of all nonconfirmed and 30.8 percent of all 536 who had a second surgical opinion. Also, as noted in other reports, a small percentage of those confirmed by the consultant still did not have the recommended surgery. This may give credence to the theory that at least some who opt for second opinion do so because they are looking for a way out of having surgery.

Estimated Economic Impact. An operation not performed saves money. This is the foundation idea on which the financial aspect of second opinion programs is built: The money saved by the patient or insurer would be the potential fee of surgeon, anesthesiologist, and assisting surgeon and the hospital bill. Offset against this, from the patient's perspective, must be the costs of alternate methods of treatment which may be small but often repetitive out-of-pocket expenses for doctor's office visits, injections, prescriptions, or other types of therapy. From the insurer's standpoint, the offset is the cost of consultations plus administrative expense and the cost of alternate treatment; the latter is difficult to quantify. Furthermore, operations may be deferred rather than cancelled and, if done a year later, the cost of operation and hospital may be higher in this era of inflation.

Thus, it is difficult to make an exact evaluation of cost-savings. The indications are that, similar to other voluntary programs, each dollar spent saved at least two dollars. This is, however, but a tiny percentage of total annual Blue Shield and Blue Cross premiums.

Quality of Care. More important than the economic impact may be the effect such a program might have on quality of care. There can be no argument that anyone is better off without a truly unnecessary operation especially if one considers the potential for complications. Equally important is the concept that a less extensive but equally efficacious procedure would appear to represent better quality care. Furthermore, the existence of a second opinion program, even if not utilized by a particular patient, may have the spinoff effect of deterring some possibly unnecessary surgery. Though hard to quantify, there likely is some positive effect on quality of care.

For the majority of opinions which are confirmatory, the patient's knowledge about and confidence in the procedure and in physicians perceptibly may tilt the balance toward better outcomes.

TABLE 1
Common Procedures

Procedure	% of Total
Hysterectomy	13.0
Cholecystectomy	6.5
Meniscectomy	4.5
Tonsillectomy and adenoidectomy	4.5
Submucous resection, nasal septum	4.5

TABLE 2
Nonconfirmed Rates, Selected Procedures

Procedure	Percent not confirmed McCarthy	BSNJ
Bunionectomy	33	73
Cholecystectomy	8	13
Dilatation and curettage	18	22
Deviated nasal septum	25	49
Hernia repair	6	25
Hysterectomy	31	37
Knee surgery	23	35
Mastectomies	17	48
Prostatectomy	29	57
Removal of cataract	15	35
Tonsillectomy and adenoidectomy	10	21
Varicose vein surgery	13	47
Overall	17	35

TABLE 3
Suggestions

	Percent
Trial of nonsurgical management	33
Further observation	23
Further tests or consultations	17
Symptoms do not warrant surgery	12
No pathology	9
Recommended surgery ineffective for condition	5
Condition resolved	2
Other factors contraindicate surgery	1

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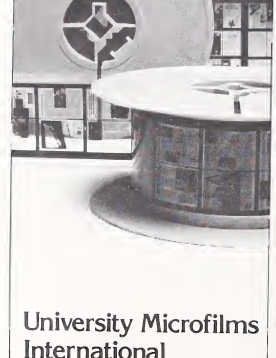
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CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients as one possible, however, that some or many of these events were drug related: Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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2) Angina where the clinical presentation suggests a possible vasospastic component
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page*

Thymoma: Unusual Case and Review of the Literature

GARY C. GARFIELD, D.O., Newark*

The differentiation between benign and malignant thymoma is difficult. A 26-year-old female, who had a "benign" thymoma resected two years earlier, developed a cough, fever, and chest pain. She did not have myasthenia gravis. Studies and thoracotomy revealed a recurrent endobronchial "benign" thymoma with extensive necrosis and a polyclonal gammopathy. We suggest that thymomas be designated as invasive or noninvasive, and with or without myasthenia gravis or other syndromes, rather than benign or malignant.

Published articles over many years attest to the controversy and disagreement regarding the histopathology, i.e. benignancy versus malignancy and the various associated syndromes, of primary tumors of the thymus.[1-3,5] Although much of the initial confusion has been resolved, unanswered questions and misconceptions remain. This article will describe a patient with thymoma with a number of unusual and previously unreported findings, and will review some of the literature on the subject.

CASE REPORT

A 26-year-old, black female was studied and treated at another medical center two years prior to the present admission to our institution. Her chief complaints were left anterior chest pain, slight shortness of breath, and recent weight loss of five to ten pounds. Physical examination and routine laboratory data were normal. The chest x-ray revealed a left parahilar mass (Figure 1). Preoperative fiberoptic bronchoscopy, arteriography, barium swallow, and gallium scan were normal.

A median sternotomy, excision of thymic mass, and partial resection of the left lung were performed. The surgical report stated: "The mediastinal mass extended into the left chest from the anterior mediastinum and laterally was found to be adherent to the left lung." The postoperative diagnosis by the thoracic surgeon was "benign thymoma of anterior mediastinum." The subsequent pathological diagnosis was "thymoma (epithelial) with massive necrosis; extension into lung (pushing in) without invasion of pulmonary tissue."

The patient was lost to followup for approximately two years until she was admitted to United Hospitals Medical Center; she complained of cough, fever, and chest pain for about one week. She had been free of any symptoms since her previous hospitalization and surgery. Again, physical examination was normal, but chest x-ray revealed a left parahilar mass (Figure 2). Fiberoptic bronchoscopy revealed a glistening fleshy white endobronchial lesion obstructing the left upper lobe bronchus. Biopsy was positive for thymoma. Thoracotomy revealed a large upper lobe tumor; a left upper lobectomy was performed. The conclusion in the pathology report was: "metastatic thymoma (malignant). The tumor is in the lung parenchyma, not by local extension from mediastinum."

DISCUSSION

The concepts of thymic tumors in the past were confused. Classifications were contradictory and earlier reported series included other neoplasms such as lymphoma and metastatic

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Figure 1—Chest x-ray reveals a left parahilar mass in our 26-year-old female patient.

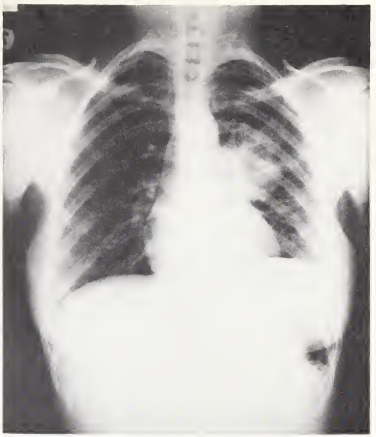


Figure 2—Two years later, chest x-ray reveals a left parahilar mass; physical examination was normal.

tumors that involved the thymus gland. Students of the subject agree the primary neoplasms of the thymus are of three major types: lymphoepithelial, epithelial, and spindle cell.[1] A major difficulty in dealing with a thymoma is to determine whether the lesion is "benign" or "malignant." In this instance, this designation is not based on histopathology which, in fact, usually does not relate to prognosis. Pathologists consider a lesion "benign" if it is encapsulated and noninvasive and "malignant" if it is unencapsulated and invasive. However, many authors emphasize the extent of invasion, as opposed to the presence or absence of a capsule.[1-5] Fechner states: "An accurate definition of invasion is important since adherence to mediastinal structures is not equivalent to invasion." According to Jamplis, "A distinction must be made between adherent and invasive, which is not always clear-cut."[2,6-9]

In our patient, no capsule was mentioned in the original surgical or pathological report; the mass was noted to be adherent to the lung, but grossly and microscopically the lesion was thought to be noninvasive or "benign." When the lesion recurred, another surgeon and pathologist failed to mention the presence or absence of a capsule. This emphasizes the difficulty in determining benignancy or malignancy and suggests that noncapsulated, adherent, but noninvasive thymomas also have a propensity to recur.

Recurrence of "benign" or noninvasive thymoma is thought to be extremely rare. In their study of 65 cases, Salyer and Eggleston wrote: "Recurrence of thymoma initially regarded as noninvasive was not observed in this series and has been uncommonly reported in the literature.[5] Fechner reported on 4 cases of noninvasive thymomas with recurrence, and found a total of 8 other cases in the literature.[6] The case presented in this paper is interesting in that it is a rare instance of recurrence of a thymoma thought to be benign. In Fechner's review of the 12 reported cases of recurrent "benign" thymomas, most reappeared in the mediastinum, with and without other areas of involvement.[6] Ours is the only case of which we are aware with recurrence as a localized pulmonary mass with large airway endobronchial involvement. Another unusual aspect of this tumor was the presence of extensive necrosis, which rarely occurs and usually is not prominent when it does.[3] Our patient also had a polyclonal increase of IgG, IgA, and IgM, not previously reported. This is particularly interesting in light of the immunologic significance of the thymus gland, and current theory that myasthenia gravis may represent an autoimmune phenomenon.[13]

Various syndromes are associated with thymomas. The most common is myasthenia gravis, which occurs in 25 to 35 percent of cases.[1-3] Occurrence of this syndrome is not related to histopathology, invasiveness, or surgical therapy. The mortality associated with thymomas, however, is most commonly due to myasthenia gravis and not to the tumor per se.[3] Patients with "benign," noninvasive thymoma are just as likely to die from myasthenia gravis as those with invasive or "malignant" thymoma. The other common cause of death in patients with thymoma is local compression of mediastinal structures and respiratory insufficiency.[3] Distant metastases in thymoma are extremely rare.[1,3]

There are many other syndromes associated with thymomas. The most commonly mentioned ones are red cell hypoplasia and Cushing's syndrome.[4] However, a review of four large series of cases, including a total of 190 patients, failed to reveal any examples of Cushing's syndrome and only three cases of red cell hypoplasia.[1-3,5] Other unusual syndromes include collagen disorders, Addison's disease, thyroid disorders, other malignancies, hypogammaglobulinemia, cerebellar ataxia, granulomatous myocarditis, constrictive pericarditis, and cardiac tamponade.[1,3,5,10-12]

SUMMARY

Thymomas are primary neoplasms of the thymus located in the anterior mediastinum. They usually occur in middle

age, but a range of 10 to 76 has been reported.[3] The male: female ratio is about equal. The clinical appearances of patients with thymoma are: asymptomatic anterior mediastinal lesions discovered by chest x-ray; chest symptoms due to compression of mediastinal structures; and symptoms of myasthenia gravis.

Invasion of adjacent structures or the development of myasthenia gravis, the two major causes of morbidity and mortality, are unrelated to cell type. The five-year survival rate is approximately 60 to 65 percent.[3] Treatment is surgical resection.

CONCLUSION

From a review of the literature and the unusual aspects of our case, it would seem reasonable that: the terms "benign" and "malignant" thymoma should be reconsidered, and thymomas should be designated as invasive or noninvasive and associated or not associated with myasthenia gravis or other syndromes (close followup care is indicated in all cases of thymomas); noninvasive thymomas ("benign") do recur and can do so as pulmonary masses with endobronchial involvement; extensive necrosis of thymomas do occur; thymomas may be associated with a polyclonal gammopathy; and thymoma-related Cushing's syndrome is not as common as previously thought.

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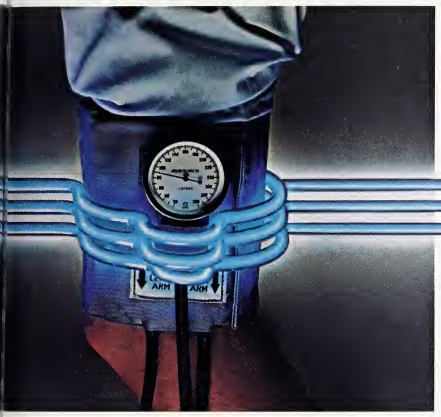
INDERAL LA offers the antihypertensive and cardiovascular benefits of INDERAL–with the additional advantage of convenient, single daily dosage. With a unique controlled-release formulation, INDERAL LA (propranolol HCl) provides sustained plasma levels and consistent, 24-hour beta blockade.

Smooth 24-hour blood pressure control

In controlled clinical studies, INDERAL LA effectively maintained systolic and diastolic blood pressure reductions with single daily dosing.

Avoids the potassium loss associated with diuretics

INDERAL LA controls blood pressure without the problem of hypokalemia often associated with long-term diuretic therapy. Like conventional INDERAL, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



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Start with 80 mg once daily...

Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. When converting patients from other beta blockers, including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary. For arrhythmias, use conventional INDERAL (propranolol HCl) tablets.



80 mg 120 mg 160 mg

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR.)
INDERAL® LA BRAND OF propranolol hydrochloride
(Long Acting Capsules)
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inorotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.
INDERAL LA capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.
INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.
The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.
In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.
In clinical use other than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.
The principal site of the antiischemic action of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.
Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is mediating harmful effects. There are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should not be impaired by the presence of a beta-receptor blocking agent. Beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be prescribed in patients subject to bronchospasm.
Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA improves exercise performance.
Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.
Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.
Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in congestive heart failure, and its inhibition by beta-blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with signs of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, patients should be digitalized and/or treated with diuretics, and the response observed closely. INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA-BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.
INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.
DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.
THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.
IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. General Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.
Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a relapse of increased intraocular pressure.
Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase
DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.
Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice receiving doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.
Pregnancy Pregnancy Category C INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.
Pediatric Use Safety and effectiveness in children have not been established
ADVERSE REACTIONS. Most adverse effects have been mild and transient and rarely require discontinuation of therapy.
Cardiovascular. bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.
Central Nervous System. lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics
Gastrointestinal. nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis
Allergic. pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.
Respiratory. bronchospasm
Hematologic. agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura
Autoimmune. In extremely rare instances, systemic lupus erythematosus has been reported.
Miscellaneous. alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA has been considered to be simple mg for mg switch for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.
HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.
ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.
If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS)
MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.
HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily
PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

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Evaluation of Hospital and Commercial Toxic Screens

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Time lapse is crucial in the definitive treatment of poisoned patients. Inhouse toxic screen in our laboratory was more sensitive and more timely when compared to a commercial laboratory. We found inhouse toxic screen to be therapeutically useful, but commercial laboratory toxic screen results were of academic interest only.

The toxicological investigations in the differential diagnosis of coma and its usefulness in the clinical management of an emergency patient suspected to be poisoned was reported by Aguilonius,[1] Lorber,[6] and Helliwell et al.[4] The morbidity and mortality caused by poisoning or substance abuse is considerable and seems to be on the rise in the United States, and, thus, it is a major public concern. Goldstein et al. reported that the number of nonfatal poisonings exceeds one million per year or 1 per 200 persons each year in the United States.[3] This high frequency of accidental or intentional poisoning may reflect the widespread increase in the availability of both prescription drugs and those obtained from illicit sources.

The toxic screen that encompasses both qualitative and quantitative analysis of drugs in poisoned patients' body fluids can be viewed to judge the severity of overdose and thus to help in the clinical care of sick patients. Toxic screen should be used to rule out overdose in patients with coma of unclear cause before initiating expensive or invasive diagnostic procedures.[4] Implicit in such a use of toxic screen is that we know its sensitivity and specificity and the results are available early enough to affect the treatment modality instituted. The above is very much dependent upon (a) analytic techniques used by the laboratory; (b) the kind of specimens subjected to analysis, e.g. serum, urine, or gastric content, alone or in various combinations, and; (c) the logistics of sending the specimens to the laboratory and the time within which analysis results are made available to the physician attending the patient. The recent report by Ingelfinger et al. casts serious doubt on the sensitivity and specificity of toxic screen in both qualitative and quantitative terms in those laboratories they chose to study this; coupled with a long delay in the availability of test results, when specimens are sent to commercial diagnostic laboratories outside the hospital, they found serious limitations on the usefulness of toxic screen in management of patients.[5]

Over the past year, The Mountainside Hospital, Montclair, which serves a predominantly middle-class, white population, has developed a cost-effective, accurate, and timely toxicology program that supports the needs of the medical staff in the diagnosis and in the clinical management of patients suspected of having been poisoned or of having taken an overdose of drugs. This study is an evaluation of the program in terms of its possible impact on the treatment modalities instituted for patient management because of the prompt availability of toxic screen results on each patient suspected of having taken an overdose.

MATERIALS AND METHODS

All patients suspected of poisoning or drug overdose admitted to the emergency room between January 1, 1981, and March 30, 1982, constituted the study population. A commercial laboraory analyzed 28 specimens, between Janu-

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TABLE 1

Dynamics of Commercial and The Mountainside Laboratories Toxic Screen Results

Variable	Site	Subjects*	Range	Median	Mode	Mean±SD	T-test/Pooled Variance T Value	T-test/Pooled Variance Est.** P Value	Mann-Whitney Z Value	U Test P Value***
[a]Time of result/report minus time of specimen collection	Commercial	49	37.0-272.00	129.00	93.00 188.00	136.12±50.43	22.07	0.000	9.26	0.000
	Mountainside	70	1.0-11.0	3.00	2.00	3.23±1.74				
Time of treatment minus time of specimen collection	Commercial	41	0.20-5.3	1.35	1.30	1.69±1.16	2.01	0.023	1.67	0.094
	Mountainside	60	0.20-4.0	1.20	1.20	1.29±0.84				
Time of result/report minus time of treatment	Commercial	41	36.05-271.0	122.0	113.00	135.20±52.49	19.75	0.000	8.51	0.000
	Mountainside	60	0.20-9.40	1.23	0.50	1.59±1.45				

*Time of treatment could not be determined in eight and ten subjects in whom toxic screen was done by commercial laboratory and The Mountainside Hospital, respectively.
**Variances were similar and thus pooled variance estimates are given.
***All *P* values given are two tail probabilities.
[a]Time in hour.

ary 1, 1981, and May 8, 1981, and 21 specimens between May 9, 1981, to October 22, 1981, respectively. The toxicology laboratory of The Mountainside Hospital analyzed 1 specimen between January 1, 1981, and May 8, 1981, 6 specimens between May 9, 1981, to October 22, 1981, and 63 specimens October 23, 1981, to March 30, 1982, respectively. The commercial laboratory did not receive any specimens from this hospital after October 22, 1981.

The following data were collected: date of admission, time of the specimen collection, time of start of initial therapy, time and date of availability of results to the hospital or the attending physician, type of specimen submitted for analysis, and the substance found in the analyzed specimen. The time of therapy could not be determined for eight patients whose specimens were analyzed by the commercial laboratory and for ten patients from The Mountainside Hospital, respectively, because no treatment was given or the time for therapeutic medication was not recorded; these patients are excluded from certain data analysis given in Table 1.

The toxicology laboratory of the hospital requests specimens of blood (plasma or serum) and urine on all patients. Other body fluids such as gastric aspirate are used when available. The analysis is done by using a spectrophotometer, color tests, thin layer chromatography (Analytical Systems, Inc., Laguna Hills, California), Emit®-ST™ Drug Detection System (Syva Company, Palo Alto, California), gas-liquid chromatography (GLC), and liquid chromatography (LC).

RESULTS

A total of 119 patients were tested by toxic screen of which 49 were done by the commercial laboratory and 70 by The Mountainside Hospital laboratory. Time-related data were analyzed as follows using the pooled data base from each of these two laboratories for the following variables:

1. Time results were reported minus time of specimen collection.
2. Time of treatment minus time of specimen collection.
3. Time results were reported minus time of treatment.

Table 1 data show that mean times for variables 1 and 3 were 136.12 hours versus 3.23 hours and 135.20 hours versus 1.59 hours for the commercial and The Mountainside Hospital laboratories, respectively. The differences have a very high statistical significance by all the tests used. Mean time for variable 2 was 1.69 hours versus 1.29 hours for the commercial laboratory and for The Mountainside Hospital laboratory. This difference is significant statistically by pooled variance estimates and by the Mann-Whitney U test, but it is just below the 5 percent significant level. Further analysis shows that the range, median, and mode values for all three variables were very much higher for the commercial laboratory in comparison to The Mountainside Hospital values (Table 1).

The profile of specimens submitted to the commercial and The Mountainside Hospital laboratories for analysis has changed dramatically. Data in Table 2 show that urine, blood or urine, and blood constituted 38.7, 12.2, and 26.5 percent of commercial laboratory specimens, respectively. Corresponding specimen profile for The Mountainside Hospital was 2.9, 20.0, and 64.3 percent. Each of these differences between commercial laboratory and The Mountainside Hospital laboratory were significant statistically. Data clearly show a significant increase in the percentage of both urine and blood specimens being submitted to The Mountainside Hospital. There were other minor differences of little or no statistical significance for other specimen(s) analyzed (Table 2).

Data in Table 3 show that the percentage of specimens found to be negative has decreased and the frequency of

TABLE 2

Profile of Specimens Used in Commercial Laboratory and The Mountainside Hospital Laboratory Toxic Screens

Site	Kind of Specimen*							
	U	B	G	U+B	U+B+G	U+G	B+G	U+B+CSF
Commercial laboratory	19** (38.7)***	6 (12.2)	3 (6.1)	13 (26.5)	3 (6.1)	3 (6.1)	2 (4.1)	0 (0.0)
The Mountainside laboratory	2 (2.9)	14 (20.0)	0 (0.0)	45 64.3	6 8.3	0 (0.0)	0 (0.0)	3 (4.1)

*U = urine, B= blood, G= gastric asplrate.
CSF = cerebrospinal fluid.
**Number of specimens submitted.
***Percentage out of total number of specimens submitted to each site.

TABLE 3

Profile of Drug Isolations in Commercial and The Mountainside Hospital Toxic Screens

Site	Total number of specimens	No. and % of negative specimens	Frequency of among total specimens	Drugs detected among positive specimens only	No. of drugs detected
Commercial laboratory	49	11 (22.4)*	1.41	1.81	27
The Mountainside laboratory	70	13 (18.57)	1.58	1.94	28

*Number in parentheses represents the % of negative specimens out of total number of specimens analyzed. The magnitude of differences between commercial laboratory and The Mountainside Hospital laboratory were not statistically significant by X^2 or student T-test.

numbers of drugs detected per specimen tested at The Mountainside Hospital has increased as compared to the commercial laboratory experience. These improvements, though not statistically significant at The Mountainside Hospital, possibly may be a reflection of the different kind of specimens being used for toxic screens at these two institutions (Table 2). However, the number of drugs detected at these two institutions has remained almost the same.

DISCUSSIONS

In patients suspected of intentional poisoning or drug overdose, besides knowledge of the substance involved and its concentration, the time when such results of toxic screen become available to the physician plays a role in the clinical management. "Toxic screen" is limited in the scope of drugs to be detected since the physician usually has some knowledge as to the probable drug(s) involved. In contrast, "coma screen" is a broader investigation of the incriminating agents ordered in such patients. If the results become available days later, they are of academic interest only. However, promptly available results are desirable and helpful in clinical management of patients.

This study compares the dynamics of a toxic screen done by an outside laboratory and an inhouse laboratory. The data, without a doubt, show that outside toxic screen could not have played any role in the treatment modality, mainly because of the long delay before results became available (Table 1). In contrast, when the toxic screen was done inhouse, this time was reduced from 136.1 hours to 3.2 hours. This reduction at The Mountainside Hospital laboratory, though a highly significant improvement by itself, becomes even more meaningful in patient management. The interval between the time of initiation of treatment and the time when results became available was on the average 1.59 hours as compared to the commercial laboratory, 135.2 hours. The Mountainside Hospital toxic screen did offer an opportunity to alter the initial medical treatment modality because of this short turnaround time.

Furthermore, The Mountainside Hospital screen offered qualitative advantages over the commercial screen, e.g. (a) more subjects were tested in which both urine and blood was analyzed; (b) the percentage of negative specimens was lower, and; (c) more specimens per subject were tested. (though not statistically significant). The type of specimens analyzed by the commercial laboratory were at the discretion of the hospital and would have impact on the results obtained. Further, the commercial laboratory picked up the specimens once a day with a promised turnaround time of not more than 48 hours for routine toxic screen. Given the implicit maximum 24-hour delay for pickup of specimens by the commercial laboratory, the turnaround time was far greater (136.1 hours) than expected. Thus, improvement in the logistics of specimen collection for the commercial laboratory (comparable to that of The Mountainside Hospital) would not have reduced the turnaround time sufficiently to have a meaningful impact on patient management. The result of this investigation has led to the development of a standard toxic screen requisition form for The Mountainside Hospital which mandates that both urine and serum specimens be submitted. The serum or plasma concentration for certain drugs, even in severe poisoning, may be too low for detection by available techniques.[7] Most of the basic drugs consisting largely of antihistamines, narcotics, analgesics, phenothiazines, stimulants, tricyclic

antidepressants, and several miscellaneous substances, achieve relatively high urine levels in contrast to their plasma concentration.[2] The sedative and hypnotic drugs develop high serum concentration even at therapeutic levels and readily are detectable. These chemically related acid and neutral drugs are metabolized thoroughly so that only a minor fraction is excreted unchanged in the urine; this makes it difficult to detect them in urine.[2] Thus, testing both urine and serum increase the sensitivity of the toxic screen. The stomach content or lavage fluids are desirable specimens when the time lapse between initial ingestion and the time the patient is examined by the physician is less than 4 hours.[7]

This study is based upon the assumption that patients who were poisoned or who had taken an overdose and whose specimens were analyzed by these two laboratories had similar characteristics. Indeed, this may not be entirely true. These highly statistical significant differences, in all probability, are a true reflection of the performance of these two laboratories at least in terms of turnaround time and not due to patient characteristics. However, we do not wish to imply that patient characteristic differences, if any, did not play some role. This study does not directly address the issue of sensitivity and specificity of the toxic screen results from various laboratories, nor does it imply that the study determines the proficiency of various toxicology and forensic laboratories. However, this study clearly points out the distinct advantage of toxic screen done in a well-equipped hospital laboratory for the physician who is treating the patient. This information permits timely adjustment in initial treatment modalities of depressed, comatosed, or excited patients due to poisoning or drug overdose. Our clinicians lost this valuable opportunity in patient care primarily due to the long turnaround time with the commercial laboratory we used. This is not to imply that commercial laboratories have no role to play in toxic screen under optimal conditions; for small hospitals with limited caseloads and laboratory facilities, use of commercial laboratories may be the only viab option.

SUMMARY

The dynamics of availability of results and the sensitivi of toxic screen determine its usefulness in the clinical ma agement of poisoned patients. Toxic screen done inhouse ha a turnaround time of 3.23 hours versus 136.12 hours for th commercial laboratory. The lapse of only 1.59 hours betwe initial therapy and availability of results with inhouse tox screen allowed modification(s) of initial treatment modali that was not possible with commercial toxic screen with lapse time of 135.2 hours. Further, the sensitivity of inhou toxic screen appeared to be greater than that of the con mercial laboratory. The study shows that the results of tox screen by this commercial laboratory appeared to be academic interest only, primarily the result of long turn around time. In contrast, the inhouse toxic screen was timely, useful, and cost-effective investigative aid in clinic management of poisoned patients.

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Sexual Abuse of Children: Rape and Incest

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Sexual abuse of children, including incest, is a highly controversial issue whose nature and prevalence only recently have become apparent. A definition, epidemiology, typical patterns in child sexual abuse and incest, and physical and psychological effects are discussed. Recommendations are made for management of cases of sexual abuse and incest.

Sexual abuse of children is the most controversial and concealed form of child abuse. Twenty years ago Kempe brought the "battered child syndrome" of physical abuse to the attention of the nation. However, it is only in the last five years, since reporting of sexual abuse has been mandated in most states, that there has been increasing awareness of the extent and seriousness of this problem. Still lacking is accurate demographic and epidemiological data or a uniformly accepted definition of child sexual abuse. It appears that the lack of systematic study of the prevalence of child sexual abuse and the implications for prevention and intervention have been hampered by society's continued denial of childhood sexuality and the shame and horror associated with the revelation of sexual abuse of children.

In this paper, we will present the following information currently available on sexual abuse of children: a definition, epidemiological data, special patterns and sequelae of sexual abuse and incest, and recommendations for intervention and management.

DEFINITION

From the legal viewpoint, sexual abuse of children is classified by the specific carnal act, that is, rape, incest, unlawful sexual intercourse, sodomy, and indecent assault. Some hold that the definition of sexual abuse requires at least a five-year age difference between the child and the offender, or the use of force, thus suggesting a power relationship rather than a true consensual relationship.[2] The spectrum of sexual abuse can range from inappropriate physical contact with fondling and general sexual overstimulation to frank sexual activity such as oral, anal, or genital sex.[3]

EPIDEMIOLOGY

As the reporting of child sexual abuse has been required by law, cumulative statistics reflect increases in incidence of between 50 to 500 percent. In a recent report, a conservative estimate of the number of children abused sexually in the United States per year was 360,000, of whom 50,000 were victims of incest.[4]

However, retrospective studies of nonclinical populations suggest a much higher true incidence of sexual abuse. For example, studies of female college students found that 26 percent reported a sexual experience with an adult prior to age 13 years, ranging from exhibitionism to coitus.[5,6] Kinsey, in his study of sexual behavior in the human female, with an all white, predominately middle-class population, found that one out of four women interviewed reported an unwanted preadolescent sexual experience with an adult male.[7]

The incidence of intergenerational incest is estimated to be as high as 5 percent of individuals, with 1 family in 100 thought to be involved.[8] While sexual contact between brother and sister is thought to be the most common form of incest, sibling incest is considered to be usually transient and to have less psychological consequence than does intergenerational incest.[9] Mother/son incest is believed to be rare and to occur where there is significant psychopathology in one or both participants.[10]

It is likely that the rate of sexual abuse is even higher among low socioeconomic families. In such families, there is

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a higher incidence of physical overcrowding and single parent families, while the presence of unrelated boyfriends or stepfathers in the home results in a weakened incest taboo.

TYPICAL PATTERNS IN SEXUAL ABUSE

Several studies report typical patterns commonly found in sexual abuse of children.[11,12] The most frequent age at which sexual abuse is reported is 11 or 12 years, but infants as young as two months of age have been abused. Approximately one out of ten reported victims are males but 97 percent of the offenders are male. Interviews with male sexual offenders have found a high incidence of sexual assault perpetrated on them when they were children.[13]

In three-fourths of the reported cases, the offender was known to the child or the family; 27 percent of the offenders lived in the child's house (a father, stepfather, mother's boyfriend, or brother). In only 25 percent of cases were the offenders total strangers. Thus, the line between rape and incest becomes blurred in the case of children. In more than 40 percent of reported cases, the abuse had occurred repeatedly, sometimes for years.

As compared to reported rapes in adult or adolescent females where 85 to 95 percent are forcible rapes, in only 37 percent of the children were the rapes forcible. The remainder involved more subtle forms of coercion, such as threats, bribes, or asserting the authority of an adult over a child.[14]

Father/daughter incest, the most frequently reported form of incest, most often occurs with prepubertal girls typically the oldest daughter, who may acquiesce on the basis of her feeling pleased by her father singling her out for special attention and physical demonstration of affection. The daughter initially may enjoy aspects of the attention from her father, and may develop an eroticized style of relating, but she finds it anxiety and guilt producing as it occurs repeatedly.[15] As the girl reaches midadolescence the situation increasingly becomes intolerable. As she develops more conscious awareness of the strength of the incest taboo, she may develop feelings of anxiety that may lead her to trying to discontinue the incestuous activity; she may run away from home, report the situation to a trusted person outside the home, tell her mother, or manifest symptoms of emotional disturbance.

EFFECTS OF SEXUAL ABUSE

Current followup studies of children who have been sexually assaulted are few and poorly done. Severe adjustment difficulties do not appear to be common in nonclinical populations. However, retrospective studies of psychiatric and/or criminal populations repeatedly have demonstrated that prostitution, promiscuity, drug addiction, and sex offenses have high correlation with sexual abuse as a child. Other associated detrimental factors, such as deprivation and family disorganization, also may be necessary etiological factors to produce such characterological difficulties.[16]

Patients in psychotherapy with a history of incest often have considerable difficulty with intimacy and separation; they tend to sexualize relationships with others and have problems with identity. These patients frequently report pronounced sexual difficulties, such as frigidity and promiscuity and unconsciously may repeat the pattern by selecting men who will sexually abuse their own daughters.[17]

Generally, a variety of physical and psychological difficulties result from sexual abuse of a child. The particular reactions and coping abilities of the child appear to be related to a complex interaction of variables, including th age, stage of development, and personality of the child; th child's emotional stability prior to the abusive incident; th responses of the family, community, and professionals to th sexual abuse; and the type of sexual activity, particularl whether coitus occurred with force and physical injury; an the relationship of the offender to the child. [3,16]

"In a recent report, a conservative estimate of the number of children abused sexually in the United States per year was 360,000, of whom 50,000 were victims of incest."

Physically, the sexual abuse may lead to genital injury, pregnancy, or venereal disease. Pregnancies occur in approximately 10 percent of reported cases of incest according to one study, with a 30 percent incidence of mental retardation and congenital defects in the offspring.[17]

Psychologically, younger children tend to show less severe effects than adolescents or older children. Younger children may develop regressive symptoms such as thumbsucking, nail biting, enuresis and encopresis, nightmares, increased fearfulness (especially of men), and psychosomatic symptoms such as vomiting, abdominal pain, and headaches. Older children and adolescents, who are capable of recognizing the inappropriateness of child/adult sex, especially intrafamilial sex, tend to have more severe reactions. These include guilt with a sense of betrayal, depression with suicidal thoughts, conversion symptoms or panic states, and a variety of behavioral disorders, including delinquency and promiscuity or prostitution.[3]

Nonviolent assault by a stranger seems to have less complex psychological sequelae. The entire family and the criminal justice system are more likely to mobilize to support the child victim against a strange attacker.[18]

INTERVENTIONS IN CASES OF SEXUAL ABUSE AND INCEST

Sexual abuse or assault of a child creates a crisis for the entire family. The reaction of the family to this crisis and the kind of professional intervention provided are the major determinants for the child's immediate and long-term welfare.

In order to ensure that all necessary examinations and treatments are done for both medical and legal purposes, it is advisable that sexually abused children and their families be referred to centers with experienced staff and physicians. Initial treatment at such centers can reduce the likelihood of additional psychological trauma through appropriate crisis intervention and referral for longer term therapy, as needed.

The following interventions are recommended when a child presents with a history of sexual abuse or incest: a history taken separately from the child and from the family members; a thorough physical examination performed in as nontraumatic a manner as possible; when appropriate, evidence collected for legal prosecution and examinations done for venereal disease and pregnancy; and an evaluation of the child's and family's psychological condition. The

Division of Youth and Family Services* must be notified and the family so advised. Any physical complications should be treated, crisis intervention provided, and referral made for longer term psychotherapy, when indicated.

When a parent seeks help for a child who has been sexually abused, the following steps should be taken: Initially the parent(s) should be seen separately to establish the history and a sense of the family dynamics; when possible, the child or adolescent should be seen separately from the parents. It is helpful to provide a young child the opportunity for play with toys to assist the physician in eliciting the information and feelings when the child is unable, or unwilling, to verbally discuss the incident.

It is important that the child have a medical examination by a sensitive physician. This examination may be done in the physician's office, or the child may be referred to a specialized center at a hospital where the staff has been trained to handle child sexual abuse.** The timing and the manner of the examination should be conducted so as not to traumatize the child unnecessarily.

The purpose and nature of the examination should be explained to the child and to the parents, both before and during the examination. The examination should be conducted in a private area, in the presence of a staff member or a relative with whom the child feels comfortable. Depending on the history, the physical examination should focus on the oral, anal, and genital areas.

The major concerns in the physical examination, besides collecting material for legal purposes, are trauma, venereal disease, and pregnancy. Swabs should be taken for gonococci and chlamydia, blood drawn for a VDRL, and pregnancy test taken on any youngster close to puberty. Each county's prosecutor's office for sex crimes recommends a particular sex crime rape kit available for the collection of evidence needed for prosecution. Sample protocols for physical examinations of sexually abused children are available in a manual published by the National Center on Child Abuse and Neglect.[19]

In some instances, in order to treat the child properly or to protect the child on a temporary basis, hospitalization may be needed. It is preferable and less traumatic for all concerned to obtain parental consent for admission, but if such consent is not possible, a 72-hour hold can be placed on the child through hospital administration.

Following the initial history, evaluations, and medical treatment, crisis intervention generally is indicated to reduce and prevent psychological trauma.[20-24] The parent(s) should be provided with factual information, reassurance, and support; a chance to ventilate feelings of anger, anxiety, and fears, which most likely center on whether the child has suffered lasting physical injury, which is rare, or psychological trauma. Their concerns often center on whether the child will be able to have normal sexual relations and to bear or father children as an adult. Parents need encouragement to provide understanding and support to the child. It also is essential that plans to protect the child from further trauma be clearly stipulated.

Parents also need to be informed that the child still needs physical affection, as some parents may withdraw from their child because they confuse any physical contact with the sexual episode. Parents need to be alerted to the possibility that their child may engage in some form of aggressive sex play with peers in an effort to master the trauma. Although this may not be a sign of serious sexual problems or incipient promiscuity, such behavior is an indication that the child would benefit from additional psychotherapeutic help to come to terms with the sexual abuse.

Our experience is that the child is most likely to be traumatized when the parents react with anger, or shame, and blame the young person for being out at a time or place they had counselled against, or when families consider their child to be tarnished or dirty, or as having provoked or initiated the assault. This perspective, which has the effect of blaming the victim, frequently occurs among health professionals as well. There continues to be a tendency to blame the child as the seducer who colludes with the rapist and to blame the mother who fails to protect her child, rather than focusing on the psychopathology of the adult who assaults the child or, when appropriate, on the dysfunctional family that permits the molestation of a minor child. It is up to the parent, not the child, to define and maintain the appropriate limits of intimacy.

A child often is incapable of refusing a beloved or admired or feared adult authority figure who is expected to protect the child and to inhibit impulses.

It is important that the child be given an opportunity to ventilate feelings of anger, hurt, shame, fear, or helplessness. The child also may need clarification of possible misinterpretations of the events that have transpired, in the context of a supportive and empathic environment.

ADDITIONAL INTERVENTIONS IN CASE OF INCEST

In contrast to the typical signs of fear, anxiety, and depression manifested by children who have been assaulted by strangers, the victim of incest may demonstrate outward calm, without showing signs or symptoms of distress.

Initially, a child who reports incest frequently is not believed. However, Kempe warns that children's reports of sexual abuse must be taken seriously and rarely are made without foundation.[25] Physicians are frequently reluctant to inquire directly if incest has occurred, even in the face of many clues. Moreover, the incest taboo is so strong, and society's general outlook so outraged and punitive, that the fear of social stigmatization often frightens family members from seeking help. There also is a strong resistance on the part of family members to continue in treatment, even after help is sought.

It is important that the physician not react with outrage at the offending parent(s). Such a reaction is likely to put the parent on the defensive and interfere with obtaining cooperation for future treatment. It equally is important for the physician to avoid the other extreme of rationalizing or justifying the behavior of the incestuous parent to avoid forming a coalition with either parent or child against one or both of the other participants in the incestuous triangle.

After the young patient confides or confirms the occurrence of incest, similar crisis interventon techniques are followed as described for sexual abuse by a nonfamily member. The child should be advised that, although this activity can happen sometimes and that is not supposed to happen, he/she will be protected against repetition of such activities in the future. If a younger daughter is present in the home, protection also should be extended to her. It is important for the health professional to provide reassurance that the child was not responsible and is not to be blamed.

*800-792-8610

**In Essex County, the CORTS program, United Hospital Center, Newark, has a Center for children where sexual abuse is suspected. Over 300 children ranging in age from 18 months to 16 years, have been seen annually since the program was established.

LEGAL INTERVENTIONS

In New Jersey, it is required by law that all cases of suspected child sexual abuse, including incest, be reported to the Division of Youth and Family Services (DYFS). In cases of incest and in many cases of sexual abuse, referral also should be made to a clinic for sexual assault victims, a mental health clinic, or an experienced psychotherapist.

The purpose of intervening in instances of sexual abuse and incest is to protect the child from continuation of the abuse and to facilitate the development of a more functional family unit. Although both DYFS and the courts can serve a useful role in protecting the child and in enforcing psychiatric treatment for family, these agencies' interventions also can add greatly to the child's trauma. For example, the child may be removed abruptly from the family and placed in foster care and then may be required to describe the incest to a series of investigative authorities, including being cross-examined in open court. The father may be imprisoned and the remainder of the family left financially destitute. The child, who is in need of protection, may instead end up with intense feelings of abandonment, combined with guilt for having been responsible for breaking up the family. And the father may be returned to the family in a relatively short period of time, unchanged, to resume his incestuous activities with that child or a younger daughter.[26]

Those treatment programs that have been most successful in helping incestuous families to stop the incest and establish a better functioning family unit have worked closely with DYFS and the courts.[27-29] These agencies are used to monitor the families closely in order to protect the child, to enforce participation of reluctant family members in treatment under threat of removal of the child or court proceedings against the abusive parent, and to place the child outside the home when his/her protection cannot be guaranteed within the family.

Further, efforts are made through consultation with the courts to reduce the psychological trauma to the child of the legal proceedings.[30] For example, should the child need to make a court appearance, arrangements could be made for testimony to be given in the judge's chambers rather than in open court.[31] Throughout the process of treatment and legal interventions, it is important that emotional support and guidance be provided to the child and the family, with close collaboration among the physician, the psychotherapist, DYFS, and the courts.

SUMMARY

There is growing awareness of the extent, nature, and effects of sexual abuse of children including incest. Unlike adult rape, most instances of sexual abuse of children are nonviolent and involve persons familiar to the child. Particularly in cases of incest, the abuse is likely to occur repeatedly over a prolonged period of time. Intervention in a case of sexual abuse of a child should include: reporting of the incident to the Division of Youth and Family Services; thorough physical examination performed in a nontraumatic fashion; and diagnostic evaluation of both the child's psychological state and the family dynamics. Treatment of physical complications, crisis intervention, and if indicated, longer term psychotherapy for family and child can be important in reducing the sequelae of sexual abuse.

In cases of incest, whenever possible, referral for evaluation and treatment should be made prior to removal of either the abused child or the offender. While protection of the child is the first priority, disruption of the family often adds to the child's trauma.

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CASE REPORT

Temporary Vocal Cord Paralysis in Fibrosing Mediastinitis

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NICHOLAS DEMOS, M.D., Jersey City*

A 61-year-old male developed hoarseness, left vocal cord paralysis, and left pleural effusion. Thoracotomy disclosed fibrosing mediastinitis with no evidence of malignancy. Subsequent laparotomy revealed retroperitoneal fibrosis. Fibrosing mediastinitis should be considered in the differential diagnosis of hoarseness.

Idiopathic fibrosing mediastinitis is an invasive process that constricts the mediastinal structures. To the multiple symptomatology of the disease, we would like to include paralysis of the vocal cords. While dysfunction of the recurrent laryngeal nerve causing hoarseness has been mentioned in the literature as an incidental finding, it has not been documented adequately.[1,2]

CASE REPORT

A 61-year-old white male was hospitalized because of hoarseness, weight loss, fatigue, and left anterior chest pain of several weeks. Two years previously, he had lumbar back pain. Physical examination revealed a well-developed adult male without any signs of chronic illness. X-rays revealed hydronephrosis of the right kidney (Figure 1). Investigation of the hydronephrosis by retroperitoneal lymphangiography showed normal paravertebral and pelvic nodes.

Chest x-ray disclosed fluid in the left hemithorax (Figure 2). Thoracentesis was performed and we removed 25 cc of fluid that was negative for malignant cells. Direct laryngoscopy revealed a paralyzed left vocal cord. Bronchoscopic examination showed a normal tracheobronchial tree. Brush biopsy of the left lower lobe produced no carcinoma cells. Through a left thoracotomy, we decorticated the left lower lobe and removed 350 cc of clear loculated pleural fluid.

There was a dense inflammatory reaction in the vicinity of the left vagus nerve and around the isthmic portion of the aorta. Frozen section, as well as permanent biopsy of fibrous tissue around the supraaortic vagus nerve and in the vicinity of the takeoff of the recurrent laryngeal nerve was negative for malignancy. Moreover, permanent tissue section consisted of hyalinized fibrous tissue with areas of fibroblastic proliferation and infiltration by plasma cells, lymphocytes, and polymorphonuclear leukocytes. The diagnosis of chronic hyalinizing pleuritis was made. The chest wall was drained by a chest tube that was removed five days postoperatively.

The patient recovered from the surgery and was free of hoarseness seven weeks later. A few months after the thoracotomy, he was admitted to a different hospital where extensive preoperative study showed only the previously recognized right hydronephrosis. At laparotomy, extensive biopsy of a retroperitoneal tumor revealed only retroperitoneal fibrosis. At the present time, 20 months after laparotomy, the patient enjoys good health, works full time, and has a normal voice. His chest x-ray has become normal with the exception of minimal superior mediastinal haziness (Figure 3).

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Figure 1—Hydronephrosis of the right kidney with normal paravertebral and pelvic lymph nodes on retroperitoneal lymphangiogram.



Figure 2—Left pleural effusion.

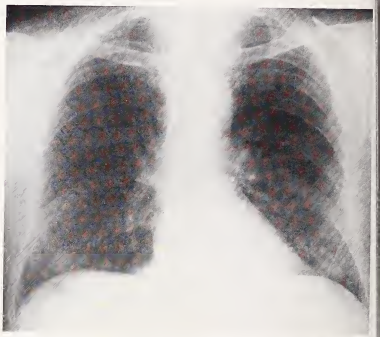


Figure 3—Essentially normal chest x-ray with some minor haziness of the superior mediastinum.

DISCUSSION

A fibrosing syndrome involving the retroperitoneal and mediastinal areas is a rare, diffuse, self-limiting chronic inflammatory reaction.

It generally occurs between the second and fifth decades and has no sex preference. Since it was first discovered, the list of signs and symptoms attributed to this disease process continually has lengthened. Ormand divides retroperitoneal fibrosis into three periods which are indicative of the disease regardless of its location:

1. Period of occurrence and establishment of the underlying disease process.
2. Period of activity-growth of fibrosis and constriction of the retroperitoneal structures.
3. Period of contraction and compression of the involved structures.[3]

The condition has been documented throughout the entire gastrointestinal tract from the esophagus to the rectosigmoid.[4,5] The cause of fibrosing mediastinitis is unknown. The first cases were attributed to syphilis or tuberculosis. Other possible causes include: radiation therapy, trauma, histoplasmosis, actinomycosis, methysergide, rheumatic fever, infection, lymphatic obstruction, vitamin E deficiency, and bacterial pericarditis. The changes found in this disease are similar to the disease processes also found in periureteric fibrosis, pseudo-tumor of the orbit, Riedel's disease of the thyroid, retroperitoneal fibrosis, sclerosing cholangitis, ligneous perityphlitis, and sclerosing cervicitis.

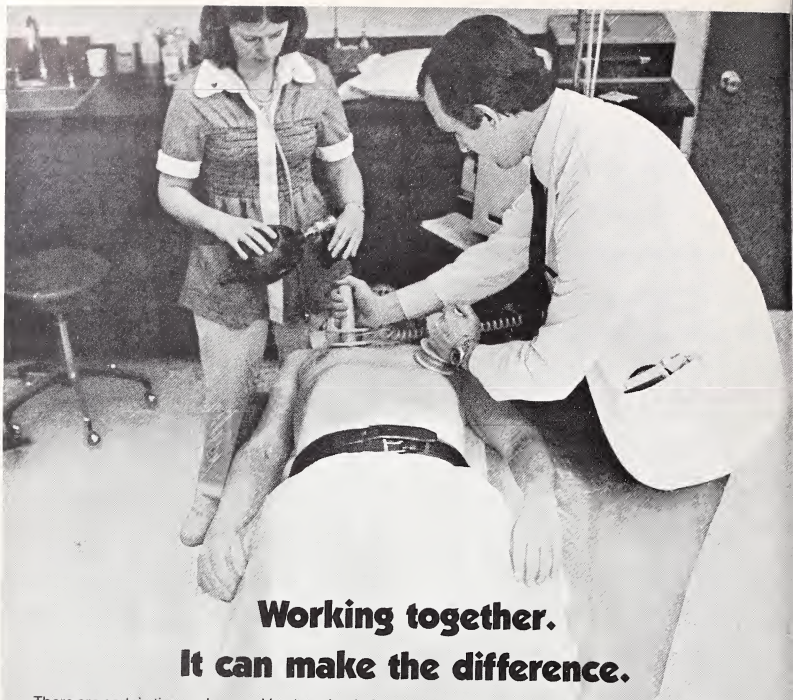
The main problem of fibrosing mediastinitis is obstruction of the superior vena cava. The most insidious of the major manifestations of the disease probably is obstruction of the pulmonary vein, which causes symptoms of cough, hemoptysis, and dyspnea. Most of these patients die from intractable heart failure or tracheobronchial hemorrhage.[6] It also has been reported to cause pulmonary hypertension by obstructing the right or both main pulmonary arteries.[7]

Koep classified pathological findings of fibrosing mediastinitis into three phases. The first phase is characterized by an active inflammatory process, in which fat islands are surrounded by areas of inflammation predominantly by round cells, lymphocytes, monocytes, plasma cells, and small numbers of fibroblasts. The second phase involves less inflammatory reaction but more fibroblasts, capillary proliferation, and collagen formation. There is diffuse periadipose, perivascular, and perineural involvement. The final phase is a very inactive stage with hyalinization, dense collagen, few cells, and markedly decreased vascularity and occasional calcification.[8] There usually is concomitant inflammation in the walls of the involved structures, as opposed to a true invasion, by the fibrous proliferative process.[2]

This self-limiting disease eventually is followed by remission of the symptoms. The treatment is mainly supportive, with steroid therapy having some use in patients with sclerosing cholangitis, retroperitoneal fibrosis, and sclerosing mediastinitis. Surgical procedures such as anastomosis of the azygos vein and inferior vena cava, bypassing the obstruction, or graft replacements of obstructed areas have been performed [11]. For the most part, these procedures have been unsuccessful due to thrombosis. Garcia et al. described a vein angioplasty of the occluded superior vena cava and azygos vein with a temporary internal shunt to help maintain the patency of the graft.[12]

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CLINICAL NOTE

Phimosis: A Cause of Renal Failure

JOEL W. ROSENBERG, M.D., Clifton*

Unrecognized obstructive uropathy can do irreparable harm to the urinary tract. Our patient developed severe chronic phimosis that led to hydronephrosis and renal failure. The problem was solved by tapering and reimplanting the ureters and by circumcision. Uncircumcised patients who neglect daily penile hygiene should be warned of this and other potential dangers and treated appropriately.

In recent years, articles have appeared in the medical and lay literature railing against circumcision as unnecessary and, in fact, a rape of the phallus.

The following case history is presented as an example of an extreme sequela of poor hygiene in the uncircumcised male.

CASE HISTORY

A 22-year-old male truck driver presented with difficulty voiding associated with hematuria.

Physical examination revealed a severe sclerosing phimosis; the urethral meatus could not be visualized. The patient admitted to voiding only in small drops for many months or longer.

Laboratory data revealed azotemia (BUN 80 mg/dl) and hyperkalemia (K+ 7.0 Meq/l). Intravenous fluids, kayexalate enemas, and parenteral antibiotics were instituted. However, it quickly became evident that definitive therapy would consist of providing relief of the distal urethral obstruction. In order to pass a catheter, an emergency dorsal slit and meatotomy were required. As soon as this was performed, there was a dramatic postobstructive diuresis; the BUN and serum potassium fell to within the normal range. The patient's well-being improved.

An intravenous pyelogram disclosed massive, long-standing bilateral hydronephrosis (Figure 1). A cystogram revealed massive bilateral reflux (Figure 2).

After the patient's medical condition was stable, we performed surgery to taper his dilated ureters and to reimplant them with an "antireflux" technique in the bladder. A circumcision also was performed.

The postoperative course was uneventful; at the time of discharge, his BUN and creatinine clearances were normal.

Three months later an intravenous pyelogram revealed an excellent result (Figure 3).

DISCUSSION

The uncircumcised male is subject to a host of possible maladies. This list is well known to most physicians and includes venereal diseases, malignancies, and inflammatory diseases. The prepuce is a preferential site of the herpes virus. It is less well appreciated that severe phimosis alone or with secondary sclerosing meatal stricture can cause obstructive uropathy. The case presented is an extreme example.

*Dr. Rosenberg is Attending Physician at Beth Israel Hospital, Passaic General Hospital, and St. Mary's Hospital, all in Passaic. Correspondence may be addressed to Dr. Rosenberg, 1198 Clifton Avenue, Clifton, NJ 07013.



Figure 1—An intravenous pyelogram disclosing massive, long-standing bilateral hydronephrosis.



Figure 2—A cystogram revealing massive bilateral reflux.

Merely relieving the distal obstruction would not have been sufficient treatment for our patient as the reflux and dilatation were too chronic to be expected to subside. Therefore, extensive urologic-plastic surgery was necessary to rehabilitate the genitourinary tract. With the satisfactory result obtained, the patient was able to void normally for the first time in his life. In addition, his sexual function and the cosmetic appearance of his penis were improved vastly.

Circumcision is an ancient operation that is tried and true. In modern times, it still is of value.

SUMMARY

A patient with renal failure and severe hydronephrosis secondary to phimosis is described. This young man's severe problem was secondary to distal obstructive uropathy due to poor hygiene of the uncircumcised penis.

Circumcision still is a valid surgical procedure and its practice is encouraged.

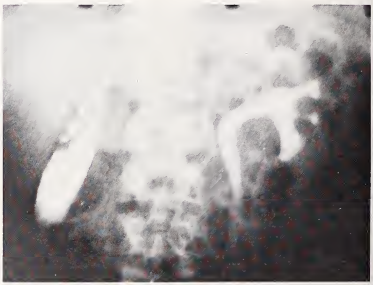


Figure 3—An intravenous pyelogram revealing the excellent results.

PEDIATRIC BRIEFS

Selected Abstracts with Comments*

Taitz LS: Soy feeding in infancy. *Arch Dis Child* 57:814, 1982. 1982.

Milk allergy is overdiagnosed. There is a whole range of vague signs and symptoms ascribed to milk allergy or intolerance, e.g. crying, vomiting, colic and transient rashes. "The danger of overdiagnosis of cow's milk hypersensitivity seems a more serious threat than its underdiagnosis. Soy has been thought to be less allergenic than cow's milk. Soy feeding was thought to prevent subsequent allergy but recent studies have shown no benefit. Soy protein probably is not less allergenic and cannot be regarded as hypoallergenic in humans .... There seems little justification for their widespread use as a substitute for cow's milk-based formula ... in genuine gastrointestinal cow's milk protein intolerance it is doubtful whether soy is appropriate because of concerns regarding its own allergenicity in this condition ... proved cow's milk protein intolerance should be treated with formulae consisting of protein hydrosylates."

Greene JW, et al.: Acetaminophen poisoning in infancy. *Am J Dis Child* 137:386, 1983.

Two infants (six weeks and seven weeks of age) suffered hypoglycemia and reversible toxic hepatitis due to home medication for fever with acetaminophen. Toxic levels were found. The authors caution that acetaminophen can be toxic and suggest closer attention to proper dosage and indications.

Comments: I cannot agree with these authors in their cautious statements. I want to say it more boldly: these infants should not have received any acetaminophen. The benefit cannot have outweighed the risks. My own preference is little or no use of antipyretics in early infancy with the exception of a dose or two (for analgesia) post-DPT immunization. The pharmacokinetics of acetaminophen and aspirin are less predictable in the small infant and therapeutic misadventure is more the rule than the exception.

Nitschke R, et al.: Therapeutic choices made by patients with end-stage cancer. *J Pediatr* 101:471, 1982.

The Oklahoma Children's Memorial Hospital Oncology Service holds a "final-stage conference" when a patient's disease processes become intransigent. Since 1974, all children (except retarded children) over the age of five have been included in these conferences. The following subjects are discussed: a review of the disease, the recent progression of the disease, the unavailability of other drugs of known effectiveness, the improbability of cure, and the imminence of death. Patient and parents are presented with a choice between the use of phase II drugs or supportive care. The results:

1. The children comprehended the prognoses and the finality of death.

2. All the children made the decision autonomously or with their parents; no child requested that his/her parents decide for him/her.

3. The decision made by patients differed in some instances from that of parents; in each such instance, the child's decision was respected.

4. Of the children who went home on supportive care, depression or severe behavioral disturbance was rare (one instance of each).

Comments: Recent research has demonstrated that healthy children over nine years of age can comprehend the meaning of death as an irreversible event. This is earlier than most persons had previously suspected. Moreover, it is the experience of many observers that children with cancer younger than nine years of age may have a death conception like that of older ones. Hence, the folks at Oklahoma Children's are on good theoretical and empirical grounds in including youngsters in an open discussion aimed at informed choice between the use of research drugs and no further chemotherapy. Prospective studies are needed to clarify further important issues regarding these children. Nevertheless, the preponderance of evidence now available supports the approach here described. That evidence also suggests that any continued efforts to exclude children are based more on grownup fears than on children's capacities and children's needs. (D. Price, Ph.D., Assistant Professor, Health Care Humanities)

Fisher D, et al.: Rapid sinus tachycardia: Differentiation from supraventricular tachycardia. *Am J Dis Child* 137:164, 1983.

The authors reported three infants with heart rates of 240 to 270 beats per minute, where rapid sinus tachycardia had to be distinguished from supraventricular tachycardia (SVT). The first patient was a seven-week-old infant with obstructive hydrocephalus, an axillary temperature of 39.5°C, with P wave morphology similar at rapid and normal heart rates, and each heart rate change was gradual. Complete recovery occurred with antipyretics. The second patient was a seven-month-old comatose infant with axillary temperature of

*Abstracts are from the Department of Pediatrics *Newsletter*, UMDNJ-New Jersey Medical School, Vol. 8, No. 4, 1983. Selections are made by Richard J. Rapkin, M.D., Medical Director of Children's Hospital, Newark, who is Editor; and by Coeditors, Franklin C. Behrle, M.D., Professor and Chairman, Department of Pediatrics, UMDNJ-New Jersey Medical School, and Shyan C. Sun, M.D., Director of Neonatology, Children's Hospital, Newark. Correspondence may be addressed to Dr. Rapkin, Children's Hospital of New Jersey, 15 South 9th Street, Newark, NJ 07107.

40°C, and blood cultures positive for *Streptococcus pneumoniae*. Cardioversion decreased the heart rate transiently from 240 to 180 beats per minute, but within 30 seconds the heart rate returned to 240 beats per minute. P waves and QRS complexes before and after cardioversion were similar. The infant died in spite of aggressive therapy, and autopsy did not disclose a diagnosis. The third patient was a 1,600-gram neonate with bronchopulmonary dysplasia who developed a heart rate of 240 per minute on routine monitoring. She was treated for clinical sepsis. Her heart rate varied from 180 to 240 beats per minutes, and her temperature from 36 to 37°C. P wave and QRS morphology were similar at both heart rates, and changes in heart rate occurred gradually within 10 to 20 seconds. The patient recovered.

The authors stress that the differentiation between rapid sinus tachycardia and SVT is: a) normal P wave preceding QRS complex in rapid sinus tachycardia and gradual onset and termination; and b) abnormal or hidden P wave morphology in SVT with abrupt onset and termination. Fever, infection, anemia, hypoglycemia, and myocardial dysfunction may cause rapid sinus tachycardia, and treatment of the underlying condition should revert the tachyarrhythmia. D-C cardioversion is of no value in rapid sinus tachycardia. Reentrant SVT usually is seen in an otherwise normal infant, and therapy is directed mainly to converting the tachycardia.

Comments: This is a valuable short article worth reading. Pediatricians are taught to believe that a heart rate over 200 beats per minute is consistent with SVT, but the authors clearly point out how one can be fooled, but also how to differentiate the two diagnoses. Therapy for SVT (be it vagal maneuvers, antiarrhythmic drugs, D-C cardioversion, or esophageal electrode pacing) is quite different from treating only the underlying condition causing rapid sinus tachycardia. (M. Prystowsky, M.D., Clinical Professor, Pediatric Cardiology)

Ryckman FC, et al.: Thoracoscopy for intrathoracic neoplasia in children. *J Pediatr Surg* 17:521, 1982.

Between 1975 and 1981, 150 thoracoscopic procedures for evaluation of intrathoracic lesions were done. Twenty-five of these procedures were for staging intrathoracic neoplasia; 48 percent were for parenchymal tumors; 44 percent for mediastinal masses; and 8 percent for pleural diseases. In 17 procedures a positive tissue diagnosis of malignancy was obtained and in 6 of these cases, areas of unsuspected intrathoracic tumor involvement were identified by thoracoscopy.

A single patient with an enlarged mediastinal lymph node had a falsely negative thoracoscopy biopsy that was read as involuted thymus tissue. Later, thoracostomy showed this to be nodular sclerosing Hodgkin's disease. Another patient with a parenchymal lesion (intraparenchymal bronchogenic cyst) had unsuccessful thoracoscopic examination.

For mediastinal disease, diagnostic accuracy was 91 percent, parenchymal lesions, 92 percent, and pleural diseases, 100 percent.

Comments: It must be mentioned that this technique is not a new one. The first thoracoscopy was introduced in 1910 primarily for lysing adhesions caused by tuberculosis in the pleural cavity. In 1915, Chevalier Jackson removed a foreign object from the pleural cavity with an esophageal speculum. The technique fell out of favor because of relatively poor optical systems employed in the past and also lack of maneuverability due to rigid thoracoscopes being used during subsequent years.

With the introduction of flexible fiberoscopes and better technology for production of much better optical systems, thoracoscopy becomes one of the best procedures short of extensive thoracotomy. This is because: a) it allows direct visual exploration of pleural cavity, the lung, mediastinal and pericardial surfaces, the diaphragm, intercostal muscles, and the blood vessels in a hemithorax; b) accurate pleural and lung biopsy can be taken under direct vision; c) immediate control of pneumothorax and hemothorax can be done; d) photographic and video tape documentation of pathologic findings can be made; e) enlarged lymph nodes are biopsied without difficulty; and f) the procedure easily can be done in a very ill patient.

The disadvantages are minimal but, just like any other procedure, this depends on who is performing it. Europeans who have had much longer experience with this procedure are expected to have fewer complications than their American counterparts who began serious attempts at it in 1973 and thereafter. (C. Dadzie, Fellow, Pediatric Intensive Care and Pulmonology)

Sacks LM, et al.: Surface cultures and isolation procedures in infants born under unsterile conditions. *Am J Dis Child* 137:351, 1983.

Cultures were obtained from infants born outside the delivery room as well as those born under usual aseptic conditions. The skin of infants born outside were frequently colonized with relatively benign flora: *S. epidermidis,* diphtheroids, *E. coli,* enterococci. After three to four days, infants born in the delivery room had a higher frequency of isolation of potential pathogens than cultures from those infants taken soon after delivery. No overt infections developed among 100 infants born under unsterile conditions. The authors conclude that taking skin cultures from such infants is not cost effective and that such infants should not be isolated.

Comments: Calling the delivery room "aseptic conditions" reminds me of Semmelweis's reporting that the mothers of Vienna in the 1860s were avoiding the hospital for fear of developing puerperal fever—a disease which occurred almost exclusively within the hospital and due to the unsterile hands of the obstetrician. Preparation of the perineum has almost nothing to do with the normal flora of the vagina *(E. coli* anaerobes, group B strep, enterococci) that colonizes the infant initially. The infant born outside the hospital may be at greater danger because emergencies such as aspiration have no available medical intervention, but the infant is almost certainly at less risk from infection. When admitted to the hospital, the infant often is isolated because it is presumed to be "contaminated." From what, the bedroom of a house, the seat of a car? There are no nurse's or doctor's contaminated hands there! This study helps to allay our concerns and shows that such infants present little or no risk to the hospital born. In fact, the reverse almost certainly is more likely.

Aftercare

)AVID I. CANAVAN, M.D., Lawrenceville*

Rehabilitation is the threshold to the lifelong process of "recovering." Two big elements are education ıbout the nature of the physician's particular impairment ınd the development of the skills necessary to cope in the :hemical-free state. While the intensive inpatient environ-nent goes a long way in accomplishing this goal, by nature of its short (4 to 6 weeks) duration, it often is not adequate o bring the physician to a level of self-confidence that will nake him comfortable in the real world.

Most treatment centers have developed structured out-patient aftercare programs for their clients so that the gains made in the inpatient program can be solidified and sup-plemented.

In many of the programs, weekly therapeutic sessions are continued for a minimum of three months after discharge and may be extended by mutual agreement if the need exists. Ordinarily, these are group sessions led by a therapist on the center staff. These meetings also allow the participants to handle the issues and problems that may have arisen in their lives following discharge from the rehabilitation program.

These are critical months in the lives and careers of our "recovering" physicians and the boost that the group provides is most constructive in getting our patients over this hurdle.

Most of our clients who have participated in formal after-care programs have considered it a very worthwhile invest-ment of time and effort.

An additional important aspect of the aftercare program involves ongoing family therapy at the treatment center. In our last article, we discussed family therapy and mentioned many resources available to the family. Some of the best resources are family programs at the rehabilitation centers. As the impaired physician begins the education and skill acquisition, family members can begin their own education and skill acquisition during the time the physician is in active treatment.

The techniques used may vary. For instance, in some programs the family actually may be in residence for several days of intensive treatment during or after the patient's stay. In others, weekly or semiweekly group sessions are held for the family members while the patient is in residence.

Whichever format is used, the program of family therapy may continue through the aftercare program, usually sched-uled to coincide in time with the sessions of the recovering physician.

Because of the significance that we attach to "aftercare" and to family therapy, during inpatient treatment and after discharge, we like to select facilities for treatment that offer reasonable geographic proximity to facilitate access to this phase.

In the unusual situation where initial rehabilitation takes place at a distant center where it is impractical for the re-covering physician and family to continue in aftercare, it is possible to enroll both physician and family in the aftercare program at a local rehabilitation center. While this is not as ideal as being able to continue treatment at the same center, it does provide an acceptable alternative.

For the physician whose problem is psychiatric rather than substance abuse, some of the same principles apply. After-care may involve continued visits to the therapist or the group at the psychiatric center where inpatient care was provided.

There is an increasing interest in providing support to the families of patients with mental illness and similar family and aftercare programs are available at some of the better psy-chiatric treatment facilities.

I cannot emphasize enough the need for continuing efforts toward recovery. These are battles that must be fought on a daily basis for the rest of the patient's life. The more vigorous the early efforts are, the more likely is success. As the time of sobriety, abstinence, recovery, and good health increases, the physician's personal program of recovery be-comes a "comfortable old shoe."

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Medicare Funds

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The fund that pays for Medicare is being depleted. A major bipartisan reform of the system is needed to prevent the collapse of Medicare. Potential solutions include: reduction of benefits, payment of hospital costs by the DRG system, increase in premiums, and raising the age of eligibility. Changes are likely to be deferred until after the 1984 election.

Medicare, the federal lifeline to health benefits for 30 million Americans, is spinning wildly out of control toward a splashdown in a sea of red ink.

The Congressional Budget Office (CBO) has reported that Medicare's Hospital Insurance (HI) Trust Fund will be depleted in 1987 unless changes are made in the current law to avoid bankruptcy. By 1995, the program would be in the red by $400 billion and would run an annual deficit of $74 billion, according to CBO projects.

The situation is so serious that Congress will have to undertake a major bipartisan reform of the system to prevent its collapse. The severity of the problem even overshadows the financial crisis faced by the recently reformed Social Security retirement system.

CBO's grim assessment was reaffirmed in the recent annual report of the trustees of the Social Security System. They noted that while the refinancing plan adopted by Congress in April spells good news for the retirement fund, the Medicare fund will go broke under any one of three sets of economic assumptions—optimistic, intermediate, or pessimistic. Only the day of reckoning changes with the differing assumptions. Under the optimistic scenario, the fund would be exhausted in 1996; under the pessimistic outlook, the fund would be depleted by 1988.

But in more gripping terms, the trustees' report states that in order to bring the Medicare fund into balance, benefits will have to be reduced by 30 percent or financing will have to be increased by 43 percent over a 25-year period.

Initial steps to come to terms with the Medicare problem were taken by Congress earlier this year when it voted to change the way Medicare pays hospitals. The new legislation phases out the current system of reimbursement based on "reasonable" costs in place of a "prospective reimbursement" plan in which reimbursement levels are determined in advance based on a schedule of diagnostic related groups (DRGs).

The new system, developed at Yale University, will not mean any savings beyond those mandated by Congress last year in the Tax Equity and Fiscal Responsibility Act (TEFRA). But it underscores congressional urgency to address the solvency issue.

In the meantime, Medicare's money problems are being examined by the 12-member advisory council on Social Security, under the direction of Dr. Otis R. Bowen. The council, charged with studying the Medicare program, was appointed last November by Richard Schweiker, former secretary of Health and Human Services, in accordance with Section 706 of the Social Security Act which requires the

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appointment of such a council every four years to study the Social Security system. Under its mandate, the council is to make its findings and recommendations before January 1, 1984.

"Only through constructive, bipartisan work can we hope to tackle the problem of Medicare and come up with a legislative package that carries the weight to pass both houses of Congress."

The council already has adopted two major proposals for overhauling Medicare which are guaranteed to trigger heated controversy in both political and medical circles. One proposal is to expand Medicare coverage and increase premiums and the second is to raise the age of eligibility.

The age proposal is expected to stir a storm of protest, particularly because it is inconsistent with the recent changes in the Social Security retirement age requirements. The council proposes increasing the age of eligibility for Medicare benefits from 65 to 67 over a ten-year period beginning in the year 2000. Earlier this year, Congress approved gradually increasing the retirement age for Social Security from 65 to 67 by the year 2027. The age would be raised to 66 over a six-year period ending in 2009 and to 67 over six years ending in 2027.

While there is likely to be some support for increasing the age for benefits under Medicare, it is doubtful that Congress would endorse conflicting ages of eligibility for retirement and health benefits. This would create a situation whereby retired workers no longer protected by their former employer's health plan would be entitled to Social Security retirement benefits but not to Medicare coverage. This gap in coverage would have to be closed to receive congressional approval.

Under the second proposal advanced by the council, Medicare patients would be eligible for up to 365 days of hospital care each year after paying an initial $350 to cover the first stay and one additional $350 payment if any additional stays are required. Present coverage provides for the initial payment and then only 59 days of free care. Substantial charges are imposed after the 59 days.

In addition, the council recommends that the out-of-pocket costs for each person who enrolled in the optional doctor insurance (Part B) program for doctor bills would be limited to $200 a year. To pay for these improvements the annual charge for enrollment in Part B, which is now $146.40 a year and will rise automatically to $176.40 in 1984, would be increased an additional $244.50 for a total of $420.90.

The added funds would not only cover the costs of added hospital and doctor benefits but raise an additional $2.4 billion in the first year to help meet the rising deficit.

If these changes in benefits and premiums were made, the council reports that most Medicare beneficiaries would not need commercial medigap insurance policies. About 65 percent of all Medicare beneficiaries buy medigap insurance to cover care and services not included under Medicare. They pay anywhere from $300 to more than $800 a year for the added protection.

While the council's study will be helpful to Congress in exploring the depths of the Medicare problem and in formulating corrective action to keep the program solvent, it is unlikely that its recommendations will be warmly embraced. Medicare is a politically sensitive issue and during a presidential election year both parties will be looking to use the issue to its maximum benefit.

Under the circumstances there is little anticipation the council can formulate a consensus plan that would receive the attention of the compromise package adopted by the bipartisan National Commission on Social Security Reform. Members of the commission were appointed by the leadership of both parties. The council members were picked by the Reagan administration.

Despite the political disadvantages, the council, however, can provide a sound starting point for congressional action by setting out clearly and unequivocally the magnitude of the problem and outlining all possible avenues of reform.

For a solution, Congress should give prompt attention to the proposal for a bipartisan panel on Medicare reform. Only through constructive bipartisan work can we hope to tackle the problem of Medicare and come up with a legislative package that carries the weight to pass both houses of Congress. This effort will require the support of the hospitals and the medical profession if we are to develop financially acceptable ways of stopping the flow of red ink that would bankrupt Medicare before the end of the decade.

Whatever changes eventually are made to protect the financial integrity of the program probably will not occur until after the 1984 elections. Neither party wants to run the risk of arousing the ire of 30 million Medicare beneficiaries at the polls.

WHAT IS YOUR OPINION?*

Health and Health Care Systems

J. RICHARD GOLDSTEIN, M.D., Trenton**

As a physician, health care planner, and your state health commissioner responsible for the health and health care systems of this state, I am in a unique position—an enjoyable position—where I can see a variety of things happening at the same time. The overall picture is what I want to relate to you. It concerns me—and should concern you—for a large part of that picture involves the medical profession. Private practitioners, group practices, HMOs, IPAs, and hospital-employed medical workers are on a collision course with each other as well as with the state's hospital industry. My impression is that many of you do not even know what is about to hit you. I am observing an accident about to happen and I want to advise you to look out!

Let us first examine how we got on this collision course. As Harvard sociologist Paul Starr notes in his most recent book, *The Social Transformation of American Medicine,*[1] with its origins in mysticism and cults, medicine eventually became a science and became credible; doctors were elevated to statuses previously reserved for academicians or other knowledgeable persons.

Starr accurately notes that this respect, which bordered on hero-worship of doctors, did not become profitable for the physician until employee groups began to bargain for health care coverage in lieu of increased wages. In making medical services available to their members, the unions simultaneously were making the provision of health benefits financially beneficial to the physicians providing them. As the demand for health benefits grew, so grew the health insurance industry. As society prospered—and protected that prosperity with increased coverage—so did the physicians prosper.

It is interesting to note that the medical community was not solely responsible for the present system of health care coverage. But, by deflecting the insurance issue into the private sector and away from service providers and consumers as well, the profession for many years was able to turn third-party insurers into tremendous allies instead of potential enemies. Eligibility for reimbursement more often determined a practitioner's financial success than meeting any licensure requirements could. With health care dollars coming out of a patient's paycheck automatically with payment guaranteed, physicians prospered. This guaranteed income increased the financial base of the entire medical care complex, and the alliance between insurer and provider became extremely beneficial—unless, of course, you were outside of the protection system.

The retired, unemployed, self-employed, or those with little or no benefits, ended up paying much more for the same coverage, if they could afford the coverage at all. The development of medical specialties only made the access situation worse because specialists, with near monopolies on their services, could demand a higher price for those services. The solution for those without insurance was Medicare and Medicaid—both opposed by organized medicine at the time.

After the government jumped on the "health care coverage" bandwagon, to increase accessibility to services, the medical profession fell into what could be called a gluttonous state. There was a smorgasbord of health care dollars to be consumed, and the medical complex ingested them readily to the point of gluttony. The notion of charity care, or working without compensation, fell by the wayside, and with this loss, the high esteem which the profession once held, began to wane. Their "windfall" profit status no longer could go unnoticed. Per capita health care expenditures in the United States jumped from $210 in 1965, to $603 in 1970, and up to $1,067 in 1980. The 10.7 billion dollars the government spent on health care in 1965 became $27.8 billion by 1970, and totaled over 104 billion dollars by 1980.

But the cost of feeding this ravenous health care system was not the only issue to surface. Government regulators asked: What are we getting for our money because the poor still were not receiving adequate care; Americans did not seem to be healthier than people in many other industrialized countries that were spending a smaller percent of their GNP; it was becoming increasingly difficult for many Americans to find a doctor on evenings or weekends; public institutions were becoming filled with the uninsured patients; and an inequitable system of cost shifting developed whereby the insured patients were paying in excess of their fair share by picking up the tab for the indigent or by subsidizing other, more costly but less used hospital services.

The ease with which the medical community could be reimbursed resulted in a medical health care system that is overly specialized, oversized, insufficient, and ineffective. A number of things are beginning to happen in response to these problems, and it is these new movements within the health care industry that I want to point out, so you can start to move with them—in the same direction—instead of

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mming into them and getting fractured in the process.

A surplus of physicians during the 1980s will increase ›mpetition for patient dollars. This excess will result in ›mpetition which, in turn, will slow the rise in health care ›sts. What you as a professional organization must realize that this new wave of competition likely will split your ınks. It will pit oldtimers against newcomers. Attempts will e made to deny young doctors admitting privileges at local ›spitals or to restrict third-party reimbursement for specific ıedical services, or to limit admissions to the medical :hool. Attempts also will be made to stop the spread of IMOs, the hospitals will undergo a very substantial re-rganization in order to compete with group practices and ther convenient, community-based services. The state's esire to regionalize expensive tertiary care services will be pposed vigorously by young specialists who will want to ractice their specialty. The unbundling of hospital services epresents a major turning point in the history of the ımerican health care system. The successful establishment f doctor-owned ambulatory care centers, urgent care cen-ers, and other more accessible, acceptable, and affordable ocally-based health services, will force hospitals to spin off ıealth care programs that can compete with these facilities. Under the umbrella of a nonprofit holding corporation, a ıospital could establish foundations for the receipt of grants, ınd then at the other end of the spectrum, could have its own or-profit corporations providing a wide range of health-elated services.

It is not an objectionable trend from my perspective. If ıospitals can become more competitive and help control :osts in that way, without compromising the quality of care ›rovided, then the citizens of this state will be the benefi-ciaries of this entire metamorphosis. But the medical pro-fession must begin to concern itself with a number of issues. In a for-profit subsidiary of a hosptal corporation, for ınstance, what kind of standard of performance will this profit-oriented entity require of its doctors? What kind of corporate thinking will they be required to assimilate? What degree of autonomy, if any, will the doctors be able to maintain? Developing good business sense or, at the very least, developing an awareness of the need to be more financially astute, is essential if the medical profession in this state is going to have any kind of an impact on New Jersey's changing health care system.

I think the DRG system has proved that physicians can be more cost conscious without jeopardizing quality of care. There were problems with the system in the beginning; that was to be expected. I think we have a viable system of reimbursement that also is providing doctors with a valuable management tool and great insight into the practice of medicine at our hospitals. In the Department of Health, we are appreciative of your adaptation to this unique system, whether voluntary or not, and of the willingness of many physicians to modify their treatment methods when it can be proved that there are equally effective but less costly ap-proaches to health care.

In those instances, you become part of the solution and not part of the problem. Several decades ago, that was the positive role you enjoyed. You were community leaders and grassroots health care providers who helped control child-hood diseases and tuberculosis, and improved maternal and infant care. You were part of the solution to a long history of health problems. Now, we need you to help solve a new problem, an economic problem. We need you to understand, to work with, and be supportive of this new, diversified approach to the provision of health care services.

To put it frankly, I feel it is time New Jersey physicians contribute once again, in a significant way, to the public health cause. After taking in so many public dollars, I believe it is time to put something back into the system. Not cash, but commitment; commitment to change—to an improved health care system.

Certainly there are enough of you to be effective in even the smallest of efforts. According to federal estimates, by 1990, there will be 79 percent more physicians in the United States than there were in 1970. By the year 2000, they project a surplus of nearly 145,000 physicians. It is this surplus, along with the restructuring of the hospital industry, that will force you into competition with one another and will threat-en the unity of the medical society. I believe that if we can focus on common public health goals, then we will be in a better position to preserve our unity, and to put something back into the health care system.

One problem we should address immediately is the infant mortality rate in many of our urban centers, and particularly among New Jersey's nonwhite population. In areas of highest infant mortality, where the availability of services often is the lowest, the use of nurse-midwives, in cooperation with a physician in the delivery of prenatal and other necessary care, has been shown to result in better birth outcomes. This collaborative management system now is used in Paterson, Jersey City, Newark, Elizabeth, Atlantic City, and Dover, and it should be encouraged in other high-need areas of the state. This program by itself is not the answer. I need your help to solve it.

A second problem we must address is substance abuse. Between 1969 and 1979, more than 6,000 drivers were killed in automobile accidents in New Jersey. Nearly half of those drivers were drunk drivers. Our drug clinics are unpopular in almost every community. They must be legitimized. I have asked the hospital association to come forward with a plan. This is a very needy and a very destructive population of substance abusers. But, they are a sick population and physicians must help.

The third issue that concerns me is somewhat related. I'm talking about risk reduction. It is not enough to treat a patient's illness. We must look at the whole patient and help him or her develop a healthier lifestyle. In recent years, New Jersey's mortality rates for breast cancer, diabetes, heart disease, and lung cancer were anywhere from 11 to 25 percent higher than the national averages (25, 18, 12, and 11 percent, respectively.) As health care professionals, we must convince patients to smoke less, drink less alcohol, eat less fat and salt, exercise on a regular basis. It is in health promotion that we could have the most significant impact on our patients, and upon the entire health care system.

The time has come for physicians to regroup, to examine the directions in which society is headed, and to chart a mutually compatible course. The alternatives are to sit back, do nothing, and witness the splintering of what could be a unified and influential professional organization, the pre-dominance of the corporate hospital, and the stagnation of New Jersey's general health status. I hope you will join together and join with me, as we move toward attainable public health goals in New Jersey.

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Trustees' Minutes July 17, 1983

A regular meeting of the Board of Trustees was held on July 17, 1983, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Report of the President . . .
AMA Alternate Delegate Position . . . Designated the President to serve as the Alternate Delegate for the 1983 AMA Interim Meeting.

Report of the Executive Director . . .
(1) Future Physician Supply in New Jersey . . . Filed Mr. Maressa's report on future physician supply and will await future available reports on the topic.
(2) MSNJ 1983 Paid Membership . . . Noted the paid membership total for June 30, 1983, at 7,201.
(3) Legal Matters . . .
(a) SBME versus Aluri; versus Strauch . . . Noted that MSNJ is appearing amicus in both cases.
(b) SBME versus Greco . . . Noted that the motion for MSNJ to appear amicus has been granted.
(c) Attorneys' Medical Malpractice Advertisement . . . Noted that the question of permissible advertising will be resolved by the Supreme Court within the next six months and complaints will be held in abeyance until final policy is developed.
(d) Jersey Shore Medical Center Medical Staff Litigation . . . Authorized the expenditure for MSNJ's legal representation as an intervenor in the case.
(4) Health Department Regulations Regarding Medical Staff . . . Directed that a response be submitted, over the signature of the President, opposing the amendments to the current medical staff section of the *Standards for Licensure of Hospital Facilities,* and highlighting the Board's particular areas of concern to the proposal.
(5) AMA Ad Hoc Committee on Women Physicians in Organized Medicine . . . Approved the following recommendation:

That the Medical Society of New Jersey cosponsors the Leadership Skills Workshop of the AMA Ad Hoc Committee on Women Physicians in Organized Medicine in Cherry Hill, on September 24 and 25, 1983, and contributes $1,000 to help defray the cost of the meeting.

(6) ACCME State Conference on Accreditation . . . Approved the following recommendation:

That William Pomerantz, M.D., Vice-Chairman of the Committee on Medical Education, and Mr. Martin E. Johnson, Director, Public Affairs and Medical Education, be authorized to attend the Third Annual Conference on Accreditation and the AMA Annual Conference on CME for State Medical Societies, at MSNJ expense.

(7) Automobile No-Fault Legislation . . . Approved the following recommendation:

That an amendment to the No-Fault Act be proposed to the Governor, stipulating that where there is evidence a physician has charged excessive fees or has been involved in over-utilization of services in a personal injury protection case, the insurance company will have the obligation to report the physician to the State Board of Medical Examiners.

Report of Legal Counsel . . .
Political Action Committees . . . Approved the bifurcated approach within JEMPAC, to place money in state and federal elections.

Council on Public Relations . . .
(1) Publicizing Information about DRGs . . . Directed that the Ad Hoc Committee on Presentation of MSNJ DRG Position address the concerns of the Council on Public Relations relative to their program on DRGs.
(2) Continuing Projects for 1983 to 1984 . . . Approved the following recommendation:

That individual projects set forth in the Council's report which have been accomplished on a continuous basis each year be approved.

(3) Media Techniques Seminar . . . Approved the following recommendation:

That the Board of Trustees approves th Media Techniques Seminar to be held at leas annually, and suggest that presidents an presidents-elect of county medical societie attend at the expense of the county.

Committee on Annual Meeting . . . Post poned until September consideration o a report that recommended that the first and second session of the House of Delegates and the Golden Merit Award Ceremony be held at the Executive Offices on April 8, 1984.

Committee on Drug and Alcohol Abuse . . . Was advised that the committee is reviewing the resolution on drunken driving.

Committee on Medicaid . . . Approved a recommendation to withhold endorsement of the Medicaid Personal Physician Plan pending a response from the Division of Medical Assistance and Health Services to questions raised by the Committee.

Committee on Medical Aspects of Sports . . . Approved the following recommendation:

That the request for endorsement of the Sport Psychology Conference being presented by the Institute for Medicine in Sports be denied.

Policymaking Subcommittee for Internal Affairs of the AMA Delegation . . . Approved the amended report from the Subcommittee dealing with guidelines for the operation of the delegation. Referred to the Special Committee on Long-Range Planning and Development Dr. Mineur's suggestion that the Board give consideration to limiting the age of candidates for AMA office as well as election to the delegation.

Executive Subcomittee, Committee on Impaired Physicians . . . Approved the following recommendation:

That the Board of Trustees authorizes the Impaired Physicians Program to solicit voluntary contributions to the Treatment and Loan Fund through *The Journal.*

ummary Report of Excessive Fee Com-laints . . . Noted that problems in the eport of the New Jersey Excessive Fee ommittee will be included on the next genda of the joint Executive Commit-ees of MSNJ and NJHA.

Blood Banking Task Force in New Jersey . . Received the statement from the New Jersey State Department of Health nd the New Jersey Blood Bank As-ociation concerning blood transfusions nd AIDS.

Old Business . . .
Blue Shield Service Benefits versus Major Medical Insurance . . . Approved for publication the report on Blue Shield Service Benefits versus major medical in-surance (se page 862).

New Business . . .
1) Daniel J. O'Regan, M.D. . . .
a) Memorial Resolution . . . Unani-mously adopted the following resolution for Daniel J. O'Regan, M.D., 1923-1983:

Whereas, Daniel J. O'Regan, M.D., died on June 17, 1983; and

Whereas, Doctor O'Regan had a dis-tinguished career as an orthopedic surgeon and in administrative capacities, and was held in high esteem by his colleagues at local, state, and national levels; and

Whereas, he served his fellow physicians well as President of the Hudson County Medical Society, President of the New Jersey Orthopaedic Society, Medical Director of the New Jersey Foundation for Health Care Evaluation, long-time Chairman of the Medi-cal Society of New Jersey Council on Legis-lation, and representative of the Medical So-ciety of New Jersey to the Health Care Ad-ministration Board; and

Whereas, he was elected as an Alternate Delegate to the American Medical Associa-tion in 1983; now therefore be it

Resolved, that the AMA Delegation and the Board of Trustees of the Medical Society of New Jersey express their sorrow at the untimely passing of Daniel J. O'Regan, M.D.; and be it further

Resolved, that deepest sympathy be ex-tended to Doctor O'Regan's family, and that a copy of this resolution be presented to Mrs. O'Regan.

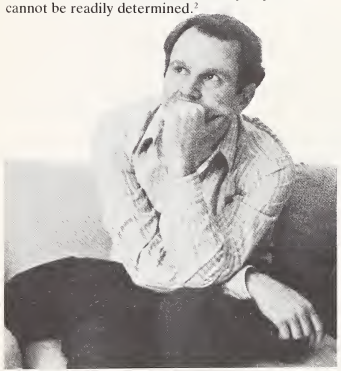
(b) Health Care Administration Board . . . Empowered the President to name a liaison representative from MSNJ to the Health Care Administration Board—a position formerly held by Dr. O'Regan.

Note: The President named Edward A. Schauer, M.D., to serve as MSNJ's rep-resentative.

(2) Payment for Physicians' Services . . . Referred to the Council on Medical Ser-vices for study and report the AMA re-

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THE MULTIVITAMIN/MINERAL FORMULATION

1. Dixon RE: *Ann Intern Med* 89(Part 2):749-753, Nov 1978. 2. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME; Philadelphia, Lea & Febiger, 1980, p. 1114.

Please see summary of product information on reverse page.

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THE MULTIVITAMIN/MINERAL FORMULATION



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Each Berocca® Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B_{12} (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide)
INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency, or conditions resulting in increased needs for essential vitamins and minerals.
CONTRAINDICATIONS: Hypersensitivity to any component
WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.
PRECAUTIONS: *General.* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient.* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions.* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.
ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.
DOSAGE AND ADMINISTRATION: Usual adult dosage, one tablet daily. Not recommended for children. Available on prescription only.
HOW SUPPLIED: Golden yellow, capsule-shaped tablets—bottles of 100.

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port and comments from Blue Shie concerning payment for physicians' se vices.

(3) Advisory Committee of the Heal Policy Agenda for the American Peop ... Authorized the attendance of th President and the President-Elect, wit expenses paid, to the first meeting of th Advisory Committee of the Health Po icy Agenda for the American People o August 29 and 30, 1983.

(4) AMA Conference on Peer Review Or ganizations and the Prospective Paymen System for Hospitals ... Authorized Dr Morrison as the Society's representative with expenses paid, to the AMA Con ference on Peer Review Organization and the Prospective Payment System fo Hospitals, September 19 to 20, 1983.

(5) JEMPAC Board of Directors .. Authorized the appointment of Pete Amirata, Jr., M.D., to the Board of Di rectors of JEMPAC.

(6) SBME and the Policy Statement or Advertising ... Noted that copies of a recently adopted policy statement concerning advertisements by licensees of the Board of Medical Examiners referring to acceptance of insurance payments will be printed in the newsletter portion of *The Journal.*

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

UMDNJ has become one of four institutions in the United States to gain approval for a two-year postgraduate medical fellowship program in surgical oncology. The program at UMDNJ-New Jersey Medical School, Newark, has received approval from the Society of Surgical Oncology, along with Memorial Sloan-Kettering Cancer Center, New York; Roswell Park Memorial Institute, Buffalo; and Ohio State University's School of Medicine, as a center for surgical oncology training.

About 15 medical centers offer two-year oncology fellowships following completion of general surgery post-graduate residency, but only these four programs have met the high standards of the Surgical Oncology Society.

The first two fellows in the UMDNJ program are M.A. Mohit, M.D., of South Orange and John Milazzo, M.D., of Elizabeth. Dr. Milazzo is a graduate of UMDNJ-Rutgers Medical School. Both physicians are Fellows of the American Cancer Society, which provides funding support for the residents and also approves the program.

George Hill, M.D., chief of the division of surgical oncology, UMDNJ-New Jersey Medical School, is in charge of the program, which includes a year on the surgical service of the East Orange Veterans Administration Medical Center and rotations at University Hospital, Newark, other UMDNJ affiliates and Memorial Sloan-Kettering Cancer Center.

Governor Kean has signed a supplemental appropriation bill allocating $530,000 to the State Department of Health for research and education on AIDS (Acquired Immunodeficiency Syndrome). Most of the money will be spent at the Newark campus of UMDNJ, with immediate priority to the purchase of a cell sorter and related equipment for an immunological laboratory and the addition of specialized personnel for AIDS research and treatment.

New Jersey ranks third among the 50 states in the number of AIDS cases reported. UMDNJ physicians and medical researchers in Newark occupy front lines in the state's battle against AIDS because most of the victims come from Essex, Hudson, and Union counties. Nearly 50 cases have been seen at University Hospital in Newark and others have been treated at hospitals affiliated with UMDNJ.

The supplemental appropriation includes about $130,000 for the State Department of Health to undertake patient support activities, laboratory and epidemiological services, and educational programs. The state money makes New Jersey eligible to apply for up to $2 million in federal funds for AIDS research.

The University plans to move aggressively to educate health professionals in New Jersey about AIDS and existing means for treating its victims.

The first regular class of the UMDNJ-Rutgers Medical School at Camden opened in August with 21 medical students. The 15 men and 6 women, who completed two years of basic sciences training at UMDNJ's Newark campus, will have two years of clinical training at Cooper Hospital/University Medical Center, Camden, a core teaching affiliate of UMDNJ. Associate Dean Ashton B. Morrison, M.D., M.B., Ph.D., directs the Camden program.

Undergraduate medical education at UMDNJ will cost students 8 percent more in 1983 to 1984 under a resolution approved by the Board of Trustees at its July 28 meeting. Tuition increases at all units of the University will produce about $980,000 in additional income to offset budget shortfalls.

The tuition increases are commensurate with similar increases proposed for Rutgers University and the New Jersey Institute of Technology and commensurate with or even less than increases being considered by public education institutions in other states.

For New Jersey residents, undergraduate medical tuition will rise from $6,325 to $6,825, for the Fifth Pathway program from $4,775 to $5,150, and for the Graduate School of Biomedical Sciences from $1,944 to $2,120.

Testing on a computerized carbon dioxide response analyzer, designed to identify potential breathing abnormalities in high-risk infants, now is available at St. Peter's Medical Center, New Brunswick, in a program in which UMDNJ-Rutgers Medical School specialists are cooperating.

Routine testing for SIDS (Sudden Infant Death Syndrome) among babies having siblings with SIDS, babies of drug addicts, and babies with bronchopulmonary and other breathing problems can identify infants at high risk. The danger then can be reduced by home monitoring, training parents in CPR (cardiopulmonary resuscitation), and other measures provided through the medical center.

Laboratory testing to identify brain and spinal defects in fetuses now is available at Middlesex General-University Hospital, New Brunswick. The amniocentesis-AFP (alpha-fetoprotein) analysis is used to check for anencephaly, encephalocele, spina bifida, and other abnormalities. The test also is offered at UMDNJ's University Hospital, Newark.

SmithKline Beckman Medical Perspectives Fellowships, recently announced by the National Fund for Medical Education, included two students of UMDNJ-New Jersey School of Osteopathic Medicine. Only two other schools—Harvard Medical School and the University of Connecticut School of Medicine—also had two students receiving the awards.

Bruce Greene, 24, a third-year student at UMDNJ-New Jersey School of Osteopathic Medicine, has left for Jakarta, Indonesia, to develop and apply a method for assessing economic factors in blindness prevention programs. He will work in cooperation with Helen Keller, International, Inc., and the Indonesian Ministry of Health.

Gloria Freundlich, 46, a fourth-year student at the school's core affiliate, Kennedy Memorial Hospitals-University Medical Center, Stratford, will leave next spring to study effects of terrorism in Israel. She will compare health, growth, and scholastic achievement of children in two Israeli communities: Kiryat Shemona, near the northern border; and Migdal Haemek, whose location is relatively free of terrorist activity.

MSNJ Auxiliary

Gale Wayman
President

The Medical Society of New Jersey Auxiliary has been busy during the summer months. We made plans for the coming year and educated our members in the ways in which they can be of assistance to the medical profession.

In June, nine members and our Executive Secretary attended the National Convention in Chicago. Along with the other delegates' duties, we helped to campaign successfully for Dr. James Todd's reelection as AMA trustee. At the convention, Mrs. Thomas McGlade, editor of the newsletter, *The Shingle,* accepted three awards for *The Shingle:* best in the category with a budget of $1,000 to $5,000, most improved in the category, and best in the nation. The plaques that we received now are hanging on the wall at MSNJ headquarters. We are very proud of *The Shingle* and of Mrs. Thomas McGlade, editor; Mrs. Ralph Fioretti, associate editor; and Mrs. Shirley Walsh, assistant editor, who have done an outstanding job.

During September, the Auxiliary Legislative Chairman, Mrs. Frank Campo, and your President attended AMPAC's Political Education Conference in Washington, D.C. This conference held workshops on such diverse topics as: The Medical Community in Campaigns, The Role of the Auxiliary, and The Media's Role in Campaigns. They proved very enlightening and their content will be reported shortly.

The MSNJ Auxiliary has been a leader in the AMA Auxiliary in working on legislation. We have sponsored two trips to Washington, D.C., and are planning another trip in April 1984, to be briefed by AMA lobbyists and meetings with our Congressmen. Several physicians have joined us in the past and we look forward to having more join us in the future. The dates for this trip will be April 11 and 12, 1984—so mark your calendars now!

Report from the Board of Trustees

The House of Delegates adopted a resolution several years ago which called for the Medical Society of New Jersey to protest to the State Insurance Department the action of the Prudential Insurance Company. At issue was the enforcement of service benefits against participating physicians of Blue Shield in the State Employees Benefit Program. Prudential, the major medical carrier, routinely would reject claims submitted by physicians who participated in the Blue Shield fixed-fee programs. These denials occurred whenever the patients were eligible for service benefits. The Medical Society of New Jersey challenged this action and argued that the existence of major medical insurance was an "asset" which barred the application of service benefits.

Prudential, Blue Shield, and the Insurance Commissioner have rejected MSNJ's position. Legal counsel has advised that there is not a reasonable probability for successful litigation of this matter.

Recently, it has been brought to the attention of MSNJ that other major medical carriers covering other employee groups are adopting a position similar to that of Prudential.

There are other related trends in the marketplace which will force patients to use "participating physicians" in various insurance plans. The AMA Council on Medical Service has pointed out that "eventually, physician's remuneration will be determined solely by third-party payors for the great majority, if not all, of the professional services they render—with what the Council believes will be a resulting inevitable mediocrity in the quality of medical care." The AMA Council believes the Association seriously should consider recommending that third parties change to an indemnity system of payment for physician services. Thus, a set amount would be paid for the service and would not be considered a service benefit.

Within this format, patients would have their access to care assured by market forces. Physicians and patients would have a heightened sensitivity to the cost and quality of care. Patients would be allowed the freedom of choice rather than being restricted to "participating" providers as a condition of coverage. Finally, the purchaser of insurance could compare the scope and cost of coverage.

Third parties would benefit through simplified administration and more accurate actuarial projections.

It also is expected that this approach would improve physician-patient interactions. It should reduce false expectations about the amount of third-party payment. Beyond that it might reduce legislative and political pressures for mandating physician participation as a condition of payment, and help preserve for physicians the freedom to charge what they believe to be fair and equitable subject to normal and effective market constraints.

This report of the AMA Council on Medical Service will be the subject of action at the Interim Meeting of the AMA in December 1983.

It is the opinion of the Board of Trustees that the adoption of the AMA Council on Medical Service position is the only reasonable means to assure physician self-determination. The adoption of this position by MSNJ does not restrict the choice of determination by any of our members. Each physician will decide his own policy. The membership therefore, is advised to weigh carefully all aspects of the participating physician concept whether it is under the Blue Shield Plan or any other third-party payor.

New Members

The Journal would like to welcome these new members to MSNJ.

Atlantic County
Michael A. Jimenez, M.D., Northfield

Bergen County
Jerome F. Levine, M.D., Hackensack
Kenneth P. Rubin, M.D., Englewood
William Alan Shapse, M.D., Englewood

Burlington County
Saroja Bharati, M.D., Browns Mills
Christina Y. Chao, M.D., Medford
Maurice Lev, M.D., Browns Mills
Martin L. Levinson, M.D., Delran
Claude D. Magnant, M.D., Moorestown
William B. Miller, D.O., Mount Laurel

Camden County
Edward M. Klein, M.D., Collingswood
Anastasios J. Pelias, M.D., Camden
Raymond T. Pekala, M.D., Barrington
Madeleine C. Weiser, M.D., Camden

Cape May County
Subhash G. Mehta, M.D., Cape May Court House

Essex County
Thomas J. Feneran, M.D., Montclair
Michael Goldfarb, M.D., Woodbridge
John F. Mendes, M.D., Glen Ridge
Gary B. Sinensky, M.D., Staten Island, NY

Hudson County
Sebastian O. Adibe, M.D., Jersey City

Mercer County
Lisa N.J. Chitour, M.D., Princeton
Ismail Kazem, M.D., Trenton
Stefan P. Kruszewski, M.D., Princeton
Samuel W. Madeira, Jr., M.D., Trenton
Richard B. Porwancher, M.D., Trenton
Julius Schwimmer, M.D., East Windsor
Myrna L. Soriano, M.D., Trenton
Telechery A. Sudhaker, M.D., Trenton

Middlesex County
Berlanta S. Antoun, M.D., Holmdel
Antonio G. Co, M.D., Edison
Se Duck Kim, M.D., Somerville
Alan S. Lichtbroun, M.D., Old Bridge
Daniel N. Mondrow, M.D., Metuchen
Yves Morency, M.D., New Brunswick
Gary S. Needell, M.D., New Brunswick
Francisco A. Salcie, M.D., Parlin
Allan D. Tiedrich, M.D., South Plainfield
Harvey S Weingarten, M.D., N. Brunswick
Stanley R. Zimmerman, M.D., Edison

Monmouth County
Richard Commentucci, M.D., Atlantic Highlands
Steven C. Hausmann, M.D., Red Bank
Christopher M. Kim, M.D., Red Bank
Raymond Mark Masterson, M.D., Sea Girt
Kenneth B. Wasser, M.D., Tinton Falls

Morris County
David J. Feldman, M.D., Denville
John Penek, M.D., Morristown

Ocean County
Edward M. Maron, M.D., Lakewood
Cary L. Pineles, M.D., Lakewood
Kul B. Sethi, M.D., Brick Town

Passaic County
Mitchel Ashkanazy, M.D., Kinnelon
Ashok Gupta, M.D., Paterson
Vincent K. McInerney, M.D., Paterson
Steven Wolinsky, M.D., Butler

Somerset County
Teresa H. Jimenez, M.D., Somerset
Seungho H. Lee, M.D., Somerville
Jamsheed K. Najmi, M.D., Bridgewater

Union County
Kenneth Y. Eng, M.D., Elizabeth
Jerome A. Molitor, M.D., Elizabeth
George Morar, M.D., Roselle Park
Judith W. Zander, M.D., Summit

Warren County
Mohamed S. Durrani, M.D., Phillipsburg
John J. Ialeggio, M.D., Phillipsburg
Charles R. Reina, M.D., Phillipsburg

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Robert M. Klein, M.D., 5959 Delafield Ave., Riverdale, NY 10471. New York Medical College 1976. Subspecialty, pediatrics. Board certified (PD); board eligible (AL). Single, multispecialty group, partnership, solo, institutional. Available July 1984.

ANESTHESIOLOGY—Robert Sackheim, M.D., 200 Carmen Ave., 2B, East Meadow, NY 11554. Guadalajara (Mexico) 1979. Group, fee for service, solo. Available.

CARDIOLOGY—Rakesh Kumar Gupta, M.D., P.O. Box 1452, Paintsville, KY 41240. All-India Institute of Medical Sciences 1975. Also, internal medicine. Solo hospital-based, group. Available.

DERMATOLOGY—Fred S. Gurtman, M.D., 3760 West Calhoun Pkwy., Minneapolis, MN 55410. Georgetown University (1974). Board certified. Group, partnership, solo. Available.

FAMILY MEDICINE—Rabie Glenoa, M.D., 105 Trenton Rd., Overbrook Hills, PA 19151. Cape Town (South Africa) 1977. Part-time family practice or emergency room. Available.

Jan D. Janeff, M.D., 168 Loomis Ct., Princeton, NJ 08540. Sofia (Bulgaria) 1953. Board eligible. Group or partnership. Available.

David Neidorf, M.D., 1701 Taxville Rd., Apt. 7A, York, PA 17404, SUNY-Stony Brook 1981. Board certified. Group, partnership, HMO. Available August 1984.

GASTROENTEROLOGY—Richard C. Dai, M.D., 16 Kenmar Dr., Apt. 127, Billerica, MA 01821. Chicago Medical School 1978. Also, internal medicine. Board certified (IM). Group or partnership. Available July 1984.

Joel Chodos, M.D., 3450 Wayne Ave., Bronx, NY 10467. Columbia 1975. Board certified. Also, general internal medicine. Group, partnership, hospital. Available July 1984.

INTERNAL MEDICINE—Helen Feit, M.D., 7-J Drummond, Rocky Hill, CT 06067. SUNY-Buffalo 1980. Board eligible. Salaried position—OPD, clinic, house physician. Available.

Richard Eanni, M.D., 19 Fernandez Ave., New Windsor, NY 12550. Rome (Italy) 1972. Also, nephrology. Board eligible. Solo (assuming practice from retiring physician) or partnership. Available.

Leonard H. Kanterman, M.D., 1405 Givens Rd., Manhattan, KS 66502. SUNY-Downstate 1977. Subspecialty, endoscopy. Board certified. Group or partnership. Available July 1984.

J. Walter Sledge, M.D., 2115 Bedford Way, Columbia, SC 29209. University of Alabama School of Medicine 1978. Board certified. Group, partnership, solo. Available June 1984.

Richard C. Dai, M.D., 16 Kenmar Dr., Apt. 127, Billerica, MA 01821. Chicago Medical School 1978. Also, gastroenterology. Board certified. Group or partnership. Available July 1984.

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*Committee on Dietary Allowances, National Research Council: *Recommended Dietary Allowances*, ed. 9. Washington, DC, National Academy of Sciences, 1980, p. 13.

Please see summary of product information on reverse page.

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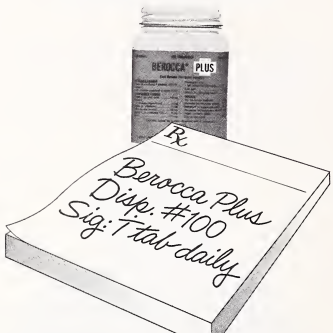
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Rakesh Kumar Gupta, M.D., P.O. Bo 1452, Paintsville, KY 41240. All-India In stitute of Medical Sciences 1975. Also cardiology. Solo, hospital-based, group Available.

Patricia M. Romano, M.D., 1077 Rive Rd., N608, Edgewater, NJ 07020. Cornel University Medical College 1979. Also pulmonary. Board certified. Group. Avail able July 1984.

Laurence M. Silverstein, M.D., 500 Ave G, #7, Redondo Beach, CA 90277. Alber Einstein 1979. Board certified. Available

Yi-po Wu, M.D., 32 Hapgood Way Shrewsbury, MA 01545. National Taiwar University Medical College 1972. Board eligible. Group or partnership.

Arvind Mehta, M.D., 8051 N. Hanover St., Anaheim, CA 92861. Seth G.S. Medical College (India) 1975. Also, nephrology. Board eligible. Solo, group, associate. Available December 1983.

NEPHROLOGY—Richard Eanni, M.D., 19 Fernandez Ave., New Windsor, NY 12550. Rome (Italy) 1972. Also, general internal medicine. Board eligible (IM). Solo (assuming practice from retiring physician) or partnership. Available.

Arvind Mehta, M.D., 8051 N. Hanover St., Anaheim, CA 92861. Seth G.S. Medical College (India) 1975. Also, internal medicine. Board eligible. Solo, group, partnership. Available December 1983.

NEUROLOGY—Elizabeth Kamenar, M.D., 12701 Shaker Blvd., Apt. 410, Cleveland, OH 44120. Ohio State 1975. Board eligible. Group, partnership, academia. Available July 1984.

Robert P. Rubens, M.D., 105 Ward St., Apt. 204, Seattle, WA 98109. UMDNJ-New Jersey Medical School 1980. Board eligible. Available July 1984.

OBSTETRICS/GYNECOLOGY—Kyung S. Cha, M.D., 240 Willoughby St., 6G, Brooklyn, NY 11201. Korea University 1973. Board eligible. Group, partnership, solo. Available.

Gary B. Steinbach, M.D., 6913 Bonnie Ridge Dr., Baltimore, MD 21209. UMDNJ 1980. Board eligible. Group or partnership. Available June 1984.

Angela McVey, M.D., 3191 Agate St., Philadelphia, PA 19134. Bucharest Medical School (Rumania) 1949. Board eligible. Group, partnership, hospital, academia. Available.

Joseph Booker, Jr., M.D., 2500 Milvia St., Apt. 228, Berkeley, CA 94704. University of California-San Francisco 1973. Partnership, group, solo. Available.

OPHTHALMOLOGY—Steven R. Davis, M.D., 1000 Lakeview Rd., Clearwater, FL 33516. University of Alabama 1975. Board certified. Solo or association. Available.

Tariq Saeed, M.D., 6906 Spourse Ct., Springfield, VA 22153. Liaquat (Pakistan) 1968. Board eligible. Group, partnership, solo. Available.

OTOLARYNGOLOGY—Richard Schiffman, M.D., 2717 East 28th St., Brooklyn, NY 11235. Tufts 1977. Board eligible. Partnership or group. Available.

ATHOLOGY—Farhad Setoodeh, M.D., 41 Wild Duck Rd., Wyckoff, NJ 07481. Jandishapur 1971. Board certified. Group or partnership. Available.

EDIATRICS—Steven Lewis Perrick, M.D., 17 Paerdegat 11 St., Brooklyn, NY 11236. SUNY-Downstate 1980. Board eligible. Partnership, solo, group. Available.

Harvey A. Hirsch, M.D., 137-03 70th Rd., Flushing, NY 11367. Guadalajara (Mexico) 1978. Associate, group, partnership, HMO. Available.

Robert M. Klein, M.D., 5959 Delafield Ave., Riverdale, NY 10471. New York Medical College 1976. Board certified (PD); board eligible (AL). Multispecialty group, partnership, institutional. Available July 1984.

Frantz Emmanuel Brea, M.D., 89-17 189th St., Hollis, NY 11423. University of Haiti 1971. Subspecialty, neonatology. Board certified, Group, partnership, institutional, solo. Available.

Kothari Purnima, M.D., 950 49th St., Apt. 8-F, Brooklyn, NY 11219. Grant (India) 1975. Board eligible. Group. Available.

PULMONARY DISEASES—M. Zaslow, M.D., 24 Westgate Rd., Chestnut Hill, MA 02167. Harvard 1977. Also, general internal medicine. Board certified (IM); board eligible (PM). Any type practice. Available.

Patricia M. Romano, M.D., 1077 River Rd., N608, Edgewater, NJ 07020. Cornell University Medical College 1979. Also, internal medicine. Board certified (IM). Group. Available July 1984.

RADIOLOGY (DIAGNOSTIC)—A. Rama Subramaniam, M.D., 186 Ellery Ave., P.O. Box 6189, Newark, NJ 07106. Stanley Medical College (India) 1964. Special interest, nuclear medicine. Solo, group, partnership, academic, hospital-based practice. Available.

SURGERY, GENERAL—Carlos A. Ferrari, M.D., 741 E. Tuscarawas, Barberton, OH 44203. Univ. National of Cordoba (Argentina) 1972. Board certified. Solo, small group, partnership. Available.

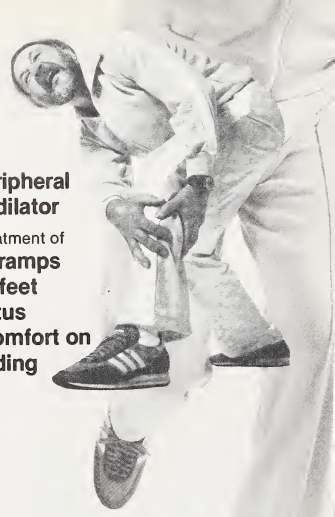
Kothari Mayur, M.D., 950 49th St., Apt. 8-F, Brooklyn, NY 11219. Addisababa (Africa) 1974. Also, vascular surgery. Board eligible. Group. Available.

Jayesh R. Modi, M.D., 740 N. Bruns La., Springfield, IL 62702. Surat (India) 1974. Also, vascular surgery. Board eligible. Partnership or solo. Available.

SURGERY, VASCULAR—Kothari Mayur, M.D., 950 49th St., Apt. 8-F, Brooklyn, NY 11219. Addisababa (Africa) 1974. Also, general surgery. Board eligible. Group. Available.

Jayesh R. Modi, M.D., 740 N. Bruns La., Springfield, IL 62702. Surat (India) 1974. Also, general surgery. Board eligible. Partnership or solo. Available.

UROLOGY—Gary Neal Dunetz, M.D., 310 LaGrange St., Chestnut Hill, MA 02167. SUNY-Upstate 1977. Group, partnership, multispecialty group. Available July 1984.



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Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

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Each yellow tablet contains:
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Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

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Each blue tablet contains:
Nicotinic Acid .....100 mg.
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Riboflavin (B-2) .....2 mg.
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MEDICAL PHILATELY

Modern Medicine Foundations

JOSEPH H. KLER, M.D., New Brunswick

MICROBIOLOGY

Roberto Koch (1843-1910) was born in Hanover, Germany. He received his medical degree from the University of Gottingen in 1866. After serving as an Army surgeon in the Prussian Army during the Franco-Prussian War, he settled in Wollstein as a district physician. Here Koch spent spare time working with a microscope. He was fascinated by microscope studies and especially so when he invented the oil immersion lens.

In 1876, Koch reported the isolation of the anthrax bacillus in pure culture and the proof of its infectiousness. Koch was the first to stain bacterial smears with analine dyes for easier study. This method is in use today.

Koch devised a liquifiable solid culture medium (gelatin) and worked out methods for obtaining bacteria in pure culture. He proved the specificity of bacterial infection in infectious diseases —his four postulates. In 1882, using these methods, Koch discovered the tubercle bacillus, the most spectacular achievement of his illustrious career. For this work, he was awarded the Nobel Prize in 1905.

When Koch began his work, the bacterial cause of only anthrax and relapsing fever had been established. Koch gave bacteriology an impetus it never had known before. He provided the initial stimulus but had developed the methods necessary for successful research in medical microbiology.

PATHOLOGY

Rudolf Ludwig Karl Virchow (1821-1902) was born in Pomerania and received his medical degree from the Friedrich Wilhelm Institute of Berlin in 1843. He is considered the outstandin physician of his generation.

In 1847, he founded the journal, *Vir chow's Archives.* In 1858, Virchow pub lished *Cellularpathologie,* one of th great books in medicine. In this work, h presented the new view "of the cellula nature of all life processes, both physi ological and pathological . . . every form of new growth . . . assumes preexisting cellular elements as its origin." This work completely displaced the age-old humoral and solidar views and caused a revolution in medical thinking.

Virchow was a brilliant investigator and an inspiring teacher who made the Virchow Institute in Berlin world famous. He also became well known as an anthropologist, archaeologist, and sanitarian who secured a good sewage system for Berlin. Virchow is considered the father of modern pathology.



Koch
Argentina, 1982



Virchow
Germany-Berlin, 1952

LETTERS TO THE EDITOR

Premedical Student Orientation

July 13, 1983

Dear Dr. Krosnick:

I am writing to give my reaction to the article by Dr. Stewart Alexander et al. in the June 1983 issue entitled, "A Community Hospital's Program for Premedical Student Orientation."

The author mentioned in the first paragraph that premedical students frequently have to work in subprofessional positions in the hospital such as orderlies, nurses' aides, stretcher transporters, or clerks. The authors feel that these positions fail to provide the learning opportunity and may be a waste of time of these talented young people.

I cannot disagree more with the above thesis. I worked for two years as an orderly in a hospital and I found it to be a most worthwhile experience and a good introduction to hospital life and organization. Physicians have to work closely with all of the "subprofessionals" and there is no better way of learning about their jobs and problems than actually working with them. I feel that my experience as an orderly was much more valuable for my growth and development than any type of premedical student orientation given solely by doctors and giving doctors' points of view of the hospital setting.

(signed) David J. Graber, M.D.

Genetic Counseling in South Jersey

July 7, 1983

Dear Dr. Krosnick:

I write to point out an inaccuracy in the UMDNJ notes in the June issue of *The Journal* of the Medical Society of New Jersey.

Dr. Bergen stated that UMDNJ is sponsoring the first genetic counseling program in South Jersey. This is an inaccuracy, since genetic counseling has been available in southern New Jersey since 1971.

I totally support the Southern New Jersey Perinatal Cooperative in association with the New Jersey School of Osteopathic Medicine in its present endeavor in providing a genetic counseling program throughout the area, but hasten to state that this inaccuracy has been pointed out to Dr. Bergen previously. To state that this is the first genetic counseling program in South Jersey is to deny the excellent work already being performed in Atlantic City and in Camden through the Osborn Family Health Center.

(signed) Courtney M. Malcarney, M.D.

CAPD and Peritonitis

July 2, 1983

Dear Dr. Krosnick:

In "Continuous Ambulatory Peritoneal Dialysis (CAPD)," by Mulgaonkar et al., 11 of 50 patients studied developed "three or more episodes of peritonitis." This represents 22 percent of the population that had at least one episode of peritonitis. There was noted to be one mortality from sepsis in their study group. As stated in their conclusion, "Peritonitis remains a major drawback of CAPD." The catheter used in this study was a Tenckhoff peritoneal catheter. We recently had been considering using the Gore-Tex peritoneal catheter. This catheter has a Gore-Tex collar which lies in the subcutaneous tissue and buttresses against the exit site. Early experience with this catheter indicates a significant drop in the incidence of peritonitis.[1]

(signed) Leonard Galler, M.D.
Shore Memorial Hospital
Atlantic City Medical Center

REFERENCE

1. Gore-Tex Peritoneal Catheter: Clinical Evaluation-Shanti Mehta W.L. Gore & Assoc., Inc., Elkton, MD, December 1, 1982.

ST. MICHAEL'S MEDICAL CENTER
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"WHAT'S NEW IN THE MANAGEMENT OF CEREBROVASCULAR DISEASE"

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For Information Call:
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Dept. of Continuing Education, St. Michael's Med. Ctr. (201) 877-5487
NO REGISTRATION FEE—2½ Hours C.M.E.—Auditorium—St. Michael's Medical Center
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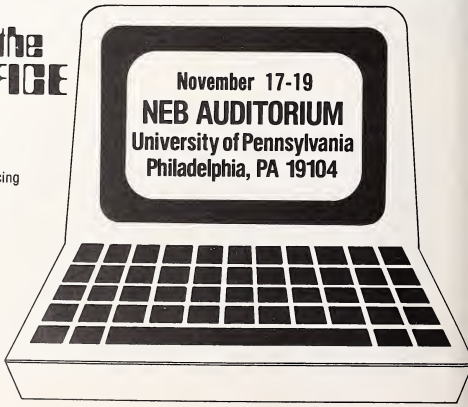
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CME CALENDAR

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Nov.

15 Nutritional Readiness for Surgery
7:45-8:45 p.m.—Ramada Inn, Clark
(NJ State Society of Anesthesiologists and AMNJ)

CARDIOLOGY

Nov.

8 Indications for Invasive and Noninvasive Cardiac Studies
7:30 p.m.—Burdette Tomlin Memorial Hospital, Cape May Court House
(AMNJ)

Dec.

7 Coronary Artery Disease
1:30 p.m.—Essex County Hospital Center, Cedar Grove
(AMNJ)

MEDICINE

Nov.

1 Nonpharmacologic Approaches to Hypertension
9 a.m.-12:40 p.m.—Atlantic City
(UMDNJ-NJ Medical School, Dept. of Medicine and Office of Continuing Medical Education, and AMNJ)

1 Nonoperative Management of Chronic Back Pain

22 Rheumatology-(Arthritis) Chronic Pain
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

1 Current Therapy of COPD
9-10 p.m.—Holy Name Hospital, Teaneck
(Holy Name Hospital and AMNJ)

2 Pulmonary Manifestations of Connective Tissue Diseases and Medications
8:30 a.m.-1 p.m.—Rutgers Medical School, Piscataway
(Arthritis Foundation, NJ Chapter, NJ Rheumatism Association, and AMNJ)

2 Medical Grand Rounds
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

2 Geriatric Pharmacology
1:30 p.m.—Essex County Hospital Center, Cedar Grove
(AMNJ)

2 Hypertension Update 1983

9 Diagnosis and Management of the Patient with Low Back Pain

16 Recent Developments in Renal Dialysis and Transplantation

23 Evaluation of Diarrhea and Its Treatment

30 Evaluation and Management of Urinary Abnormalities in an Office Practice
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

2 Endocrine Conferences

9 3:30-5 p.m.—Rotates between Newark

16 Beth Israel Medical Center, University

23 Hospital, United Hospitals Medical

30 Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

2 Pathophysiology and Management of Congestive Heart Failure
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

2 Lower Extremity Ischemia
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

3 Medical Grand Rounds
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section, AMNJ)

3 Immunological Markers in the Diagnosis of Leukemia and Lymphoma
11 a.m.-12:30 p.m.—St. Joseph's Hospital
(St. Joseph's Hospital and Medical Center and AMNJ)

3 Update on Cutaneous Malignancies
8-10 p.m.—Bergen County Medical Society, Hackensack
(NJ Medical Women's Association and AMNJ)

4 Medical Grand Rounds
11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section, AMNJ)

4 Renal Conferences in Nephrology

18 4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMNJ)

Fourth Annual Case Conference

5 8:30 a.m.-5:30 p.m.

12 9 a.m.-12:15 p.m.—Scanticon Conference Ctr., Rt. 1, Princeton
(NJ Thoracic Society and AMNJ)

9 Crises in the Critical Care Units
8:30 a.m.-2:45 p.m.—Hilton Hotel, Tinton Falls
(NJ Society of Critical Care Medicine and AMNJ)

10 Immunology Update
2-3 p.m.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

15 Toxic Shock Syndrome
12 noon—St. Mary's Hospital, Orange
(AMNJ)

16 Rutgers Dermatological Conference
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

16 Crystal-Induced Joint Diseases

23 Hyperlipidemia Update
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center, Lyons, and AMNJ)

16 Clinical Controversies in Diabetes Mellitus
9 a.m.-5 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

16 Stone Disease
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

16 Diabetic Eye Disease
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

17 Evaluation of the Bleeding Patient
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

17 Regional Hospital Meeting Case Presentations
8-10 p.m.—Somerset Medical Center, Somerville
(NJ Gastroenterological Society and AMNJ)

18 Thyroid Disease
1:15-3 p.m.—Marlboro Psychiatric Hospital
(Marlboro Psychiatric Hospital and AMNJ)

19 Update of Infectious Diseases—1983
8:30 a.m.-1:30 p.m.—Stevens Center, Stevens Institute of Technology, Hoboken
(Hudson County Medical Society, Hospitals of Hudson Cty., and AMNJ)

22 FVIII Inhibitor Management
6:30-10 p.m.—Landmark Inn, Woodbridge
(NJ Blood Club and Hematology Section, AMNJ)

30 Emergency Care
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(AMNJ)

30 Anaerobic Infection

NEW JERSEY
HEALTH SCIENCES GROUP
presents a symposium on

FRONTIERS IN BIOMEDICAL RESEARCH—1983

WEDNESDAY, NOVEMBER 9, 1983

AT

UMDNJ-RUTGERS MEDICAL SCHOOL, PISCATAWAY, NEW JERSEY

1:00 P.M.-9:00 P.M.

For Further Information Contact:

Linda Bartolo
Executive Secretary
New Jersey Health Sciences Group
Two Princess Road
Lawrenceville, New Jersey 08648
Phone: (609) 896-1717

NEW JERSEY SOCIETY OF PATHOLOGISTS

ANNUAL SLIDE SEMINAR
SATURDAY, NOVEMBER 12, 1983
AT
UMDNJ-RUTGERS MEDICAL SCHOOL, PISCATAWAY, NEW JERSEY
9:00 A.M.-1:00 P.M.

ON

SURGICAL PATHOLOGY OF THE TESTES AND ITS APPENDAGES

SPEAKER:

HOWARD S. LEVIN, M.D.
Department of Pathology,
The Cleveland Clinic Foundation,
Cleveland, Ohio

A wide variety of cases submitted by members will be discussed. Members will receive slide sets and case histories. A limited number of slide sets are available to non-members for $35.00

OBJECTIVE: The participants will be better able to diagnose reactive and malignant diseases as well as functional abnormalities of the testes and its appendages.

For Further Information Contact:

Cathy Gillmer
Executive Secretary
New Jersey Society of Pathologists
Two Princess Road
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Phone: (609) 896-1717

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WEDNESDAY, NOVEMBER 2, 1983

UNSTABLE ANGINA PECTORIS

MODERATOR: BERNARD L. SEGAL, M.D.

3:00 CASE PRESENTATION — *Ioannis Panidis, M.D.*
3:30 CLINICAL MANIFESTATIONS OF UNSTABLE ANGINA — *Stuart Snyder, M.D.*
4:00 THE ELECTROCARDIOGRAM IN THE PATIENTS WITH UNSTABLE ANGINA PECTORIS — *Gary J. Anderson, M.D.*
4:30 CARDIAC CATHETERIZATION IN THE PATIENTS WITH UNSTABLE ANGINA PECTORIS — *Mark F. Victor, M.D.*
5:00 COMPARATIVE CLINICAL PHARMACOLOGY OF BETA-BLOCKERS AND CALCIUM-CHANNEL BLOCKERS — *Joel Morganroth, M.D.*
5:30 PANEL DISCUSSION

LECTURE HALL "A"—2nd floor New College Building, Hahnemann University
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1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

ec.

1 **Medical Management of Peptic Ulcer Disease**
8 **Immune Reconstitution**
11 a.m.-12:30 p.m.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

1 **Prescribing for the Elderly**
8 **Special Medical Update: Heart Attack-Beta-Blocker Trial Studies**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

2 **Renal Conferences in Nephrology**
6 4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMNJ)

6 **Management of Hepatitis**
0 **Cardiology-Clinical Arrhythmias**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

7 **Fluid & Electrolyte Imbalance**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

7 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

7 **Loopholes in Management of Serious Infection**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

7 **Update on the Treatment of Paget's Disease for the Primary Physician**
9-10 p.m.—Alexian Brothers Hospital, Elizabeth
(Alexian Brothers Hospital and AMNJ)

7 **Endocrine Conferences**

14 3:30-5 p.m.—Rotates between Newark
21 Beth Israel Medical Center, University
28 Hospital, Newark, VA Medical Center, East Orange, and United Hospitals Medical Center, Newark
(Endocrinology Section, AMNJ)

8 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section, AMNJ)

8 **Aches and Pains in Children**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

9 **Medical Grand Rounds**
11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section, AMNJ)

14 **Diagnosis and Management of Problems Due to Bleeding and Clotting Defects**
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

14 **Step Therapy for Angina Pectoris**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

14 **Congenital Pulmonary Anomalies**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

16 **AIDS**
12 noon—Freehold Area Hospital
(AMNJ)

20 **Sleep Apnea**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

21 **Invasive Hemodynamic Monitoring**
10:30 a.m.—South Bergen Hospital, Hasbrouck Heights
(AMNJ)

21 **Medical Uses of Angioplasty**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

21 **AIDS and Other Infections**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

NEUROLOGY/PSYCHIATRY

Nov.

2 **Clinical Treatment of Depression in Office Practice**
9-10 a.m.—Alexian Brothers Hospital, Elizabeth
(Mead Johnson and AMNJ)

2 **Management of the Violent Patient**
1:15-3 p.m.—Marlboro Psychiatric Hospital
(Roerig Pharmaceuticals/Marlboro Psychiatric Hospital and AMNJ)

2 **A Family Systems Perspective in Mental Health**
8-10:30 p.m.—South Orange Middle School, North Ridgewood Rd., South Orange
(Mental Health Assn. of Essex County, National Assn. of Social Workers, NJ Psychiatric Assn., NJ Psychological Assn., and AMNJ)

3 **Psychological Assessment of Dementia and Depression in the Aged**
10 **Treatment and Research Outcomes in Schizophrenia**
17 **The Cult Phenomena and Treatment**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

4 **Centralized Residency Training Program**
11 1:30-5 p.m.—Trenton Psychiatric
18 Hospital
(Trenton Psychiatric Hospital and AMNJ)

7 **Phobic Symptoms in Borderline Women**
8:15 p.m.-10:30 p.m.—4 Garden Place, Nutley
(Essex Psychiatric Seminar and AMNJ)

15 **Drug Addiction**
3 p.m.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

16 **Industrial-Occupational Medicine and Psychiatry**
9:30 a.m.-4:30 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

21 **Principles of Child Psychotherapy**

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8:30-10:30 p.m.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

Dec.

5 Lecture Series
8:15 p.m.-10:30 p.m.—192 Chittenden Rd., Clifton
(Essex Psychiatric Seminar and AMNJ)

7 Memory Loss, Confusion, and Dementia in an Office Practice
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

13 Psychopharmacology
12 noon—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

19 Principles of Child Psychotherapy
8:30-10:30 p.m.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

OBSTETRICS/GYNECOLOGY

Nov.

Update in Perinatology—1983

11 9 a.m.-5 p.m.—Morristown Memorial Hospital

12 9 a.m.-12 noon
(Morristown Memorial Hospital and AMNJ)

22 Ovarian Cancer
9-10 a.m.—Holy Name Hospital, Teaneck
(Holy Name Hospital and AMNJ)

PATHOLOGY

Nov.

3 Genetic Etiology of Cancer

10 Genetic Control of the Transformed Tumorigenic Phenotypes

17 Transforming Proteins of DNA and RNA Viruses
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

9 Pathology Grand Rounds
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

12 Surgical Pathology of the Testes and Its Appendage
9 a.m.-1:00 p.m.—Rutgers Medical School, Piscataway
(NJ Society of Pathologists and AMNJ)

Dec.

1 Protooncogenes: Mechanisms of Activation

8 Transfection and Human Oncogenes

15 Viruses Associated with Human Cancer
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

14 Pathology Grand Rounds
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

21 Slide Seminar/New Procedure Update
7-9 p.m.—Hyatt House, Cherry Hill
(South Jersey Pathology Society and AMNJ)

PEDIATRICS

Nov.

7 Pediatric Endocrinology
6-10 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

10 Advances in Neonatology
9 a.m.—Freehold Area Hospital
(AMNJ)

22 Common Problems in the Adolescent Patient
8:30-10:30 a.m.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

RADIOLOGY

Nov.

5 Real-Time, Cross-Sectional Sector Scanning
9 a.m.-5 p.m.—Nassau Inn, Princeton
(The National Foundation of Non-invasive Diagnostics and AMNJ)

9 Newer Modalities in Diagnostic Radiology
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

16 Dinner Meeting—Carcinoma of the Cervix
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

23 Advances in Imaging Techniques: CT and NMR
10:30 a.m.-12 noon—St. Mary's Hospital
(St. Mary's Hospital and AMNJ)

Dec.

8 Fundamental Principles of Doppler Ultrasound
7:30-10 p.m.—UMDNJ-Rutgers Medical School, Piscataway
(NJ Institute of Ultrasound in Medicine and AMNJ)

15 Radiology Meeting
7:30-10 p.m.—St. Barnabas Medical Center, Livingston
(Radiological Society of NJ, Radiology Section, and AMNJ)

SURGERY

Nov.

16 Examination of Compensable Injuries
7:15 a.m.—Point Pleasant Hospital
(Point Pleasant Hospital)

21 Surgical Treatment of Morbid Obesity-Selection of Patients and Long-Term Results
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

22 Head and Neck Tumors in Children
8:30-9:30 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

SURGICAL SPECIALTIES

Dec.

14 Examination of Compensable Injuries
7:15 a.m.—Point Pleasant Hospital
(Point Pleasant Hospital)

20 Cancer Surgery of the Breast
8:30-9:30 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

MISCELLANEOUS

Dec.

1 Learning, Speech, and Language Disorders
9 a.m.—Freehold Area Hospital
(AMNJ)

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 25-hour accredited seminar and workshop on the latest theories & techniques of manual and electro-acupuncture, applicable toward the 200-hour requirement for certification, will be given for licensed clinicians (with or without prior training) during the weekend of November 18-20, 1983 and again the weekend of January 25-27, 1984 at the Barbizon Plaza Hotel, New York City. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its official journal (published by Pergamon Press) the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital, Pharamcology Dept. of The Chicago Medical School. Also eligible for AMA/CME credit. For information, contact Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I), NYC 10032, Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.

NYU Post-Graduate Medical School

presents:

November

11, 12 Chymopapain for Neurosurgeons and Orthopedists
14-18 Clinical Pharmacology and Toxicology: The Use, Misuse and Abuse of Drugs

December

3, 4 Chymopapain for Neurosurgeons and Orthopedists
3-4 Basic Review of Pathology and Radiology for Urologists
7-9 Clinical Electrodiagnosis of Neuromuscular Disease
8-10 Cancer Surgery 1983
10-11 Operative Urology
12-14 Managing Clinical Problems in the Elderly
14-18 Computed Tomography

Information: NYU Post-Graduate Medical School, 550 First Avenue, New York, NY 10016 (212) 340-5295

OBITUARIES

Dr. Joseph J. Blake

A family practitioner, Joseph John Blake, M.D., died on June 25, 1983, at the age of 61. Dr. Blake received his medical degree from Jefferson Medical College, Pennsylvania, in 1950. During his career, Dr. Blake was affiliated with the West Jersey Health System in Camden, Berlin, and Voorhees. Dr. Blake was a member of our Camden County component and of the American Medical Association, a Diplomate of the American Board of Family Practice, and a Fellow of the American Academy of Family Practice.

Dr. Louis J. Bohl

At the grand age of 92, Louis Joseph Bohl, M.D., died on June 3, 1983. Dr. Bohl was graduated from Maryland Medical School in 1917 and completed an internship at St. Joseph Hospital, Paterson, and later served on the staff. In 1967, Dr. Bohl received MSNJ's Golden Merit Award for 50 years of service to his community. Dr. Bohl was a member of our Passaic County component and of the American Medical Association, and a Fellow of the American College of Surgeons.

Dr. Daniel E. Boyle

At the age of 66, Daniel Edward Boyle, M.D., died at his home after a long illness on July 15, 1983. Dr. Boyle was a retired psychiatrist, affiliated with the Yardville Youth Reception and Correction Center and St. Francis and Helene Fuld Medical Centers, both in Trenton. In 1942, Dr. Boyle earned his medical degree from Hahnemann Medical School, Philadelphia. Dr. Boyle was a past president of the Mercer County Medical Society, a member of our Mercer County component and of the American Medical Association, and a Fellow of the American Psychiatric Association.

Dr. Charles C. Buford, Jr.

At the untimely age of 62, Charles Conrad Buford, Jr., M.D., died on June 25, 1983. Dr. Buford was affiliated with Mercer Medical Center, Trenton, and Trenton Psychiatric Hospital. Dr. Buford earned his medical degree from Meharry Medical College, Tennessee, in 1945. A member of our Mercer County component, Dr. Buford also was a member of the American Medical Association.

Dr. Joseph P. Calderone

At the untimely age of 53, Joseph Philip Calderone, M.D., died on July 10, 1983. Dr. Calderone, an otolaryngologist with a practice in Elizabeth, was affiliated with Alexian Brothers Hospital, General Hospital, and St. Elizabeth Hospital, all in Elizabeth. Dr. Calderone earned his medical degree in 1955 from Georgetown University Medical School, Washington, D.C., and served his internship in Saint Michael's Medical Center, Newark. A member of our Union County component and of the American Medical Association, Dr. Calderone was a Diplomate of the American Board of Otolaryngology.

Dr. Clara E. Dailey

Word has been received of the death of Clara Evans Dailey, M.D., in May 1983. Born in 1912, Dr. Dailey earned a medical degree from Temple University School of Medicine, Pennsylvania, in 1938. A family practitioner, Dr. Dailey was affiliated with Franklin Hospital. Dr. Dailey was a member of our Sussex County component and of the American Medical Association.

Dr. Anthony J. De Vita

Word has been received of the death of Anthony James De Vita, M.D. Dr. De Vita was born in 1907 and earned his medical degree at Boston University School of Medicine, Massachusetts, in 1934. After 42 years of medical practice, Dr. De Vita retired in 1976; he had served at Monmouth Medical Center, Long Branch, and Riverview Hospital, Red Bank. Dr. De Vita was a retired member of our Monmouth County component.

Dr. Felix J. DiFino

A lifelong resident of Newark, Felix Joseph DiFino, M.D., died on June 16, 1983. Born in 1906, Dr. DiFino earned his medical degree at George Washington University School of Medicine, Washington, D.C., in 1931. Dr. DiFino received MSNJ's Golden Merit Award for 50 years of service to the Ironbound Section of Newark. A retired member of our Essex County component, Dr. DiFino was a member of the American Medical Association and a Fellow of the American College of Surgeons. During his lengthy career, Dr. DiFino was affiliated with Clara Maass Memorial Hospital, Belleville, as chief of surgery.

Dr. G. Hathaway, Jr.

A member of our Passaic County component, George Hathaway, Jr., M.D., died on July 14, 1983. Born in 1916, Dr. Hathaway received his medical degree from Cornell University Medical College, New York, in 1942. Dr. Hathaway was a family practitioner affiliated with General Hospital and Saint Mary's Hospital, both in Passaic. Dr. Hathaway was a member of the American Medical Association.

Dr. Robert J. LaMagra

At the untimely age of 42, Robert Joseph LaMagra, M.D., died on June 17, 1983. Dr. LaMagra was an attending physician at Monmouth Medical Center, Long Branch. A graduate of the

Medical School at the University of Bologna, Italy, in 1972, Dr. LaMagra interned at Monmouth Medical Center in 1973. Dr. LaMagra was a Fellow of the American College of Obstetricians and Gynecologists, a Diplomate of the American Board of Obstetrics and Gynecology, and a member of our Monmouth County component.

Dr. John G. Lima

John Gandolfo Lima, M.D., died on June 7, 1983. Dr. Lima earned his medical degree from Georgetown University Medical School, Washington, in 1938. Dr. Lima had a family practice in Passaic and until last year was director of the continuing medical education department at Greater Paterson General Hospital, Wayne. Dr. Lima was a member of our Passaic County component and of the American Medical Association and a Fellow of the International College of Surgeons.

Dr. Meyer E. Mackler

A retired member of our Passaic County component, Meyer Edward Mackler, M.D., died on June 7, 1983. Born in 1908, Dr. Mackler received his medical degree from the University of Louisville School of Medicine, Kentucky, in 1937. Dr. Mackler was a member of the staff of Barnert Memorial Hospital Center, Paterson, after serving his community for 45 years, and a member of the American Medical Association.

Dr. Rudolph G. Matflerd

Rudolph Gustave Matflerd, M.D., former chief of surgery at St. Peter's Medical Center, New Brunswick, died on June 5, 1983. Dr. Matflerd was born in 1919 and earned his medical degree at University of Rochester School of Medicine, New York, in 1945. A member of our Middlesex County component and of the American Medical Association, Dr. Matflerd was a Diplomate of the American Board of Surgery, and a Fellow of the American College of Surgery. During his career, Dr. Matflerd was affiliated with John F. Kennedy Medical Center, Edison, Middlesex General Hospital, New Brunswick, and Raritan Valley Hospital, Greenbrook.

Dr. Thomas G. McAveney

A retired ophthalmologist, Thomas Gibney McAveney, M.D., died on June 1, 1983. Born in 1908, Dr. McAveney was graduated from Long Island College of Medicine, New York, in 1931. Dr. McAveney was an ophthalmologist for Western Electric Corp., Kearny, for 31 years and served on the staff of St. Mary's Hospital, Orange, and the United Hospital and Medical Center Eye Institute, Newark. A member of the American Medical Association, Dr. McAveney was a retired member of our Essex County component.

Dr. George J. McDonnell

At the age of 76, George J. McDonnell, M.D., a member of our Monmouth County component, died on June 2, 1983. Dr. McDonnell was a physician in Freehold since 1935, affiliated with Freehold Area Hospital and Jersey Shore Medical Center, Neptune. Dr. McDonnell received his medical degree from Cornell Medical School, New York, in 1933 and completed his internship at Monmouth Medical Center, Long Branch. Dr. McDonnell led efforts in Monmouth County against tuberculosis as Chairman of the Tuberculosis Control Program and Clinic and was the coordinator for the Salk polio vaccine program in Monmouth County.

Dr. Leon P. Nutzel

A member of our Essex County component, Leon Philip Nutzel, M.D., died on June 25, 1983. Born in 1920 in Newark, Dr. Nutzel earned his medical degree from Georgetown University School of Medicine, Washington, D.C., in 1945. A family practitioner for over 30 years, Dr. Nutzel was affiliated with Clara Maass Memorial Hospital, Belleville, The Mountainside Hospital, Montclair, and Children's Hospital of New Jersey, Newark. Dr. Nutzel was a member of the American Medical Association and a Fellow of the American Academy of Emergency Room Physicians.

Dr. Daniel J. O'Regan

Daniel James O'Regan, M.D., died on June 17, 1983. Dr. O'Regan served as the medical director of the New Jersey Foundation for Health Care Evaluation, and was active on MSNJ's Council on Legislation, serving as its chairman. Dr. O'Regan was born in 1923 in Jersey City, and earned his medical degree at Georgetown University Medical School, Washington, in 1952. A member of our Hudson County component, Dr. O'Regan was a Diplomate of the American Board of Orthopedic Surgery, a Fellow of the American College of Surgeons, a Fellow of the International College of Surgeons, and a member of the American Medical Association. He was affiliated with St. Francis Hospital and Pollak Hospital, both in Jersey City.

Dr. Fulvio Patella

Fulvio Patella, M.D., a member of our Passaic County component, died on June 2, 1983. Born in 1899, Dr. Patella received his medical degree from the Faculty of Medicine University of Naples, Italy, in 1923. Dr. Patella was affiliated with St. Joseph Hospital and Medical Center, Paterson, and Saddlebrook Hospital. Dr. Patella was a member of the American Medical Association.

Dr. Joseph G. Stella

Joseph G. Stella, M.D., died on July 16, 1983, at the age of 63, following heart surgery. Dr. Stella graduated from Temple University School of Medicine, Pennsylvania, in 1950. During his career, Dr. Stella was affiliated with Atlantic City Medical Center, where he served as the chief of radiation therapy, and with Shore Memorial Hospital, Somers Point. He was a member of our Atlantic County component, a Diplomate of the American Board of Therapeutic Radiology, and a Fellow of the American College of Obstetricians and Gynecologists.

Dr. Edward J. Thalheimer

At the age of 82, Edward James Thalheimer, M.D., died on June 18, 1983, after a long illness. Dr. Thalheimer earned his medical degree from Yale Medical College, Connecticut, in 1926. A pediatrician, Dr. Thalheimer practiced in Vineland until retiring in 1976. A member of our Cumberland County component and of the American Medical Association, Dr. Thalheimer was a Fellow of the American Academy of Pediatrics.

Dr. Robert F. Zimmerman

Robert Fairchild Zimmerman, M.D., an affiliate member of our Morris County component, died on June 20, 1983. Born in 1904, Dr. Zimmerman was awarded a medical degree from Columbia University College of Physicians and Surgeons, New York, in 1936. A member of the American Medical Association and a Fellow of the American College of Surgeons, Dr. Zimmerman was affiliated with Memorial Hospital, Morristown, and Cape Cod Hospital, Massachusetts.

Annual Review of Immunology, Volume I

William E. Paul, C. Garrison Fathman, Henry Metzger (eds). Palo Alto, CA, Annual Reviews, Inc., 1983. Pp. 666. ($27)

For many years, I have been a reader of *Annual Review of Medicine* by the same publisher. These texts always have been interesting and well balanced as to content and highly informative. This book as regards immunology maintains the same high scholarly standards.

Editor William E. Paul and Associate Editor Henry Metzger are from the National Institute of Health; and Associate Editor C. Garrison Fathman is from Stanford University.

The text is a hard-covered, firmly bound book, comprised of 22 chapters and a ten-page subject index; after each chapter is a very current list of references.

The subjects range from an autobiographical history by Elvin A. Kabat to T-lymphocyte clones. The other chapters include almost all topics related to modern immunology, such as histocompatibility T-cell and B-cell interaction and immunoglobulin genes. Each chapter is written by one, two, or three authors, experts in their various fields.

This is not a textbook for the beginner. The *Review* appears to me as a book telling of the "state of the art" concerning research immunology. To quote from the preface written by Dr. William Paul: "Immunological science is in the midst of a revolution. The introduction of monoclonal antibody methodology and somatic cell genetics, and the development of methods to grow cloned lymphocytes in long-term culture have made possible experiments that, even a few years ago, would have been regarded as science fiction. The immune system is the most important defense against pathogenic microorganisms, and may be critical in prevention and therapy of neoplastic diseases. Its primacy in these areas is tragically emphasized by the recent emergence of a new human disorder—Acquired Immunodeficiency Syndrome."

Such is the nature and content of this highly scientific book. It is strongly recommended to all scientists who are interested in immunology.

Hugh F. Luddecke, M.D.

An Atlas of Normal and Abnormal Mammograms

Ted Nathan, M.D. New York, NY, Oxford University Press, 1982. Pp. 118. ($59.50)

The author indicates in the preface to this text that "the book is intended primarily for radiologists training in mammogram interpretation, and for surgeons with a particular interest in the management of patients with mammary disorders. It is not meant to be an authoritative treatise on the subject."

To this limited extent, the author succeeds in presenting an interesting atlas of mammograms for the student of mammography, much in the manner of the traditional "teaching file" prevalent in the modern department of radiology. The discussion is concise and relevant, especially the section on malignant lesions of the breast.

The shortcomings of the book relate to the sometimes suboptimal image quality of the radiographs, the sparse text relating to analysis of the normal mammogram, and the relatively superficial discussion of mammographic technique, radiation protection, and possible carcinogenic effect of low level diagnostic radiation exposure to the human breast. The indications for mammography and the possible risk of carcinogenesis are extremely important subjects for the student mammographer and breast surgeon to comprehend.

Edwin S. Wilson, M.D.

Comprehensive Group Psychotherapy

Harold I. Kaplan, M.D., and Benjamin J. Sadock, M.D., (eds). Baltimore, MD, Williams & Wilkins Company, 1983. Pp. 375. ($35)

In *Comprehensive Group Psychotherapy* the authors discuss the emotional and psychiatric disorders according to the American Psychiatric Association's new *Diagnostic and Statistical Manual of Mental Disorders* (DSM III). The organization of the various chapters remains essentially similar to that of the first edition but many innovations and special chapters have been added. With the wider acceptance of group psychotherapy as a mode of treatment, the section of international group psychotherapy is a most timely addition.

The various authors have maintained a unified approach in the description of the mode of group therapy in their respective countries which, therefore, seems to take away the sparkle that one experiences in many of the other chapters.

The focus on education, legal, ethical, and research topics not only is conceived excellently but brings these issues into clear focus. Other chapters, such as psychotherapy with groups in special categories have been reworked and updated and the new developments in each category have been added.

The many new approaches, such as the use of videotapes, art, dance therapy, and other specific methods, add an extra dimension to this already quite inclusive work. A minor flaw is the rather small print that makes reading somewhat tiresome.

The authors and editors have given both the seasoned and the developing therapist a most inclusive and excellently written reference book to group therapy —a most laudable effort.

Karl J.F. Gossner, M.D.
Associate Clinical Director
Carrier Foundation

Digital Nuclear Medicine

Jon J. Erickson, Ph.D., and F. David Rollo, M.D., (eds). Philadelphia, PA, J.B. Lippincott Company, 1983. Pp. 240. ($20.75)

This book is a condensation of lectures given by the nuclear medicine and radiologic physics faculty at Vanderbilt University from 1977 through 1982.

Digital Nuclear Medicine achieves its purpose in a concise and well-written format. The book clearly explains the concept of computer data processing. It also details the concept of processing of images so that intelligent diagnostic decisions can be made. Most of the chapters are written for advanced technologists, be they in radiology or nuclear medicine, as well as physicians with an interest in computerized nuclear medicine. It is most appropriate for physicians with an interest in nuclear cardiology. Dr. Rollo, a well-known authority in the field of nuclear medicine, does an excellent job in the chapters, "For Nuclear Cardiac Studies" and "Emission Tomography Studies." Both of these areas of application are growing in nuclear medicine and this book, I believe, is an invaluable reference to gain additional technical expertise in this growing area.

The numerical calculations shown, images displayed, and analysis of images displayed are worked out in a reasonable fashion.

My only criticism is that the actual illustrations used are not of the highest quality. However, it must be recognized that the book is not designed for clinical instruction but primarily designed to enhance comprehension of clinical computer techniques.

I would recommend this book strongly as resource material for all radiology residents and residents in nuclear medicine, as well as technologists, so they best understand image processing in the 1980s.

Louis S. Zeiger, M.D.

Essentials of Gastrointestinal Radiology

Browyn Jones, M.D., and John M. Braver, M.D. Philadelphia, PA, W.B. Saunders Company, 1982. Pp. 215. ($22.50)

This slim volume succeeds admirably in its stated purpose of giving the newcomer to gastrointestinal radiology a knowledge of basic principles. The text begins with a discussion of anatomy and techniques, and then shows how to apply these in the diagnosis of the broad categories of disease such as ulcer, inflammation, and neoplasm which have similar radiologic manifestation throughout the gastrointestinal tract. Clinical considerations are emphasized and find expression in valuable chapters on the emergency patient, pseudolesions, and iatrogenic complications. There are useful sections also on small bowel disease, vascular lesions, and the post-operative patient. The final chapter on the biliary system and pancreas is a succinct, clinical approach to diagnostic problems in this area. The illustrations, roentgenograms and occasional line drawings are clear and adequately supplement the text. I recommend this book to those wishing to learn the essentials of the subject. Experienced practitioners will find it a readable review of the present state of the art.

Leonard S. Ellenbogen, M.D.

Patients' Rights and Professional Practice

James T. Ziegenfuss, Jr., Ph.D., M.P.A. New York, NY, Van Nostrand Reinhold Company, 1983. Pp. 233. ($19.95)

Patients' Rights and Professional Practice attempts to bridge the gap between patients' rights and professional prac-

The *Journal* of the Medical Society of New Jersey

announces the publication of the

WILLIAM CARLOS WILLIAMS COMMEMORATIVE ISSUE

September, 1983

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es in caring for the institutionalized ental patient. James T. Ziegenfuss, Jr., .D., M.P.A., presently serves as a nsultant to the Commonwealth of nnsylvania, Office of Clients' Rights. r. Ziegenfuss exhorts his professional lleagues to champion the causes of tients' rights in the interest of quality tient care. His book contains a set of ractical guidelines which facilitate pa- nts' rights while advancing the quality care. A chapter is devoted to each of ne enumerated "patient rights" cate- ories as rights on admission, environ- ental rights, treatment, medical rights, onfidentiality, visitation and com- unication, freedom of movement, free- om from abuse, money and property ghts, and various other civil rights. ach chapter contains case examples nd a discussion of the legal, ethical, and ractical issues raised in the cases.

The chapter dealing with the patient's ght to refuse treatment may be the hapter of greatest concern to the treat- ig psychiatrist. Unfortunately, it also ay be the most disappointing for the eader who is seeking definitive legal uidelines. The chapter is flawed by an adequate discussion of the landmark New Jersey case of Rennie *v* Klein. The hapter does not contain the opinion of he federal appellate court which ul- imately decided the case. Rather, it ontains a discussion of the district court pinion that was modified substantially y the appellate court.

On the whole, this reviewer shares the uthor's perspective that the prudent esponse to the demand for patients' ights is to design effective treatment rograms. The guidelines suggested by Dr. Ziegenfuss in this book may serve as nodels. In today's legal climate, failure o address the issue of patients' rights nly can lead to further involvement of he courts in the mental health system.

James E. George, M.D., J.D.

Principles of Clinical Electrocardiography

M.J. Goldman, M.D. Los Altos, CA, Lange Medical Publications, 1982. Pp. 438. ($15)

This text is the 11th edition of a fine book on principles and interpretation of electrocardiography. It begins with a primary description of the subject and progresses to the ultimate purpose of the book: the understanding and interpretation of the electrocardiograph in clinical practice.

The purpose of this new edition is to update changes that have occurred in the past three years in the rapidly expanding field of electrocardiography. Many of the chapters have little or no change but others such as cardiac pacing, pre-excitation, stress exercise testing, and drug interactions contain the latest information as of 1982.

This book is a good primer of electrocardiography especially for the medical student and resident. There is a good chapter on vectorcardiography that is a small book in itself. The appendices at the end are worth the price of the entire book in their summary of the normal electrocardiogram, common abnormalities, differential diagnosis of the adult 12 lead electrocardiogram, and the application of statistics to electrocardiography. These latter are distillates of the total knowledge at the present.

This book is recommended as an excellent bedside helper in electrocardiography. The illustrations are of the highest quality and very explanatory.

Manuel J. Rowen, M.D.

The Psychosocial Aspects of Pediatrics

Dane G. Prugh, M.D. Philadelphia, PA, Lea & Febiger, 1983. Pp. 688. ($65)

Since the early 1970s many books and articles have been written to enlighten child care professionals and the public regarding our current knowledge (or deficiencies) concerning behavioral pediatrics. Dr. Prugh has added a classic in this endeavor. With his vast experience he has assembled in this volume a broad scope of material. At times, it may appear the surface of each topic is touched upon, however, the extensive bibliography following each chapter would invite the reader to more comprehensive learning.

Pediatricians and allied para-professionals always have dealt with a good percentage of emotional problems daily. With today's ever-changing society of increasing divorce rates, single parenting, and pre-K schools, this book takes on added timely significance.

The author tries to maintain a good striking balance of material between physiologic, psychologic, and social context. The psychotherapeutic aspects of the role of the pediatrician (or family practitioner) are valued and emphasized. However, consultation is tactfully suggested in the more chronic and involved psychiatric problems. Simply stated, Dr. Prugh has divided his book into four parts. Part I deals with basic background material emphasizing the development of the child's personality. Part II deals with general clinical considerations emphasizing the need to recognize, categorize, and treat emotional and mental disorders. Part III deals with specific clinical entitities and their management. Not only are classical psychiatric diseases discussed but also the management of children's reactions to hospitalization, fatal illness, and handicaps is included.

Part IV, a single chapter, deals with trends of the future in child health care. Emphasized here is the need to educate our medical students and residents in psychosocial aspects of disease, and, importantly, the involvement of the government to insure nonfragmented care for all children.

This handsomely bound book should rank high in priority for all child health-care professionals.

Frank C. Vanore, M.D.

Training and Conditioning of Athletes, 2nd Edition

Max M. Novich, M.D., and Buddy Taylor, M.S. Philadelphia, PA, Lea & Febiger, 1983. Pp. 320. Illustrated. ($16.50)

This update of one of the earliest books (1970) of its kind in the sports medicine field is worthy of a place on every trainer's and team physician's library shelf.

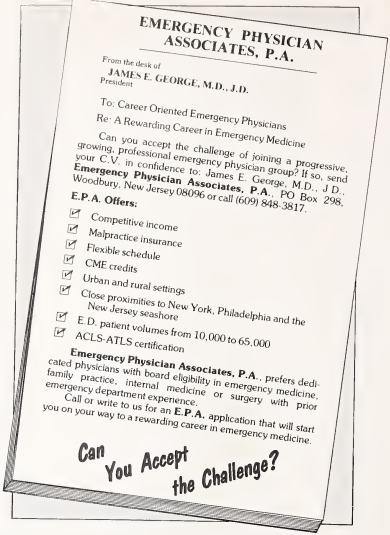
The book is filled with a wealth of practical know-how based on long experience in the conditioning and training of athletes by the authors and an upbeat philosophic outlook.

While concentrating mainly on the orthopedic aspects of sports injuries and particularly their prevention and rehabilitation, the text also has good chapters on nutrition and drugs in sports. Other medical aspects are mentioned in passing, but anyone desiring this information can obtain it from one of the more general texts on sports medicine.

Some very practical material on the physical organization of a trainer's room, his/her game bag, equipment, and the preparticipation examination of the athlete including examples of forms to be used also are included.

Overall, the book is readable, there are adequate illustrations, and it is well organized.

Christine E. Haycock, M.D.


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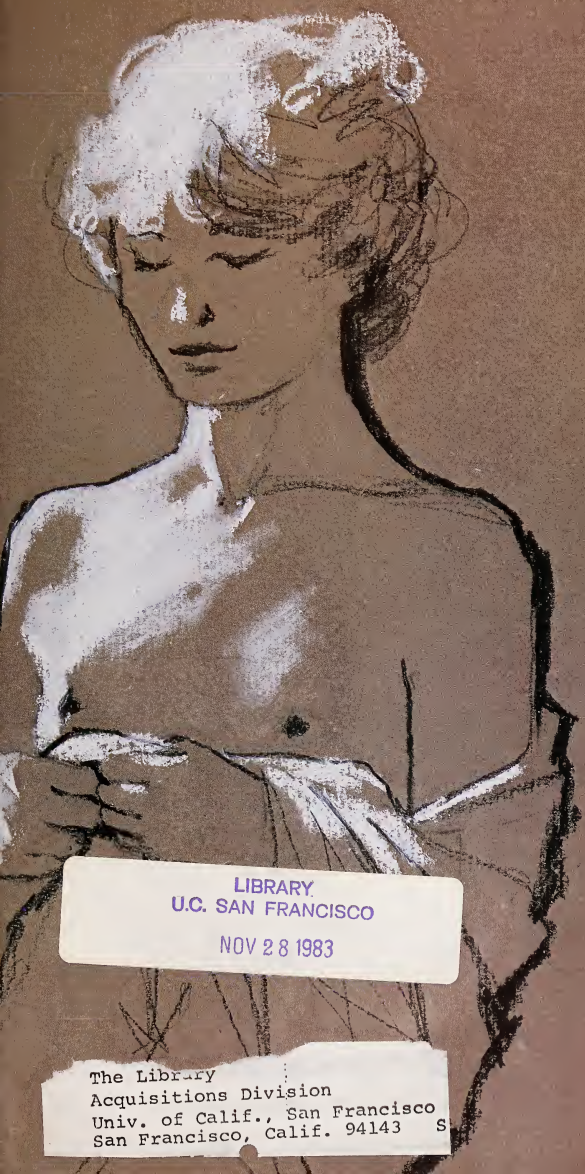
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Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist. use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated)

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (.2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; shoul these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood coun liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropen In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL: *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal mus spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; c 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initiall increasing as needed and tolerated (see Precautions) Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal dail dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 m daily when 5 mg oral Valium has been determined as the optimal daily dose (u for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patien and when sedative drugs are added. (See Warnings and Adverse Reactions.) For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repea in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer I.V. slowly*; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (IV preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow IV preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful. In endoscopic procedures, titrate I.V. dosage to desired sedative response, gen ally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes pri to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatol has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue) bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

ROCHE®

MEMBERSHIP NEWSLETTER



MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 4

ANALYSIS OF BLUE SHIELD PROGRAM

The Blue Shield participating physician contract orm seems rather simplified. It carries with it, however, rather serious implications to the contracting hysician.

The physician agrees to perform the services enuerated in subscription certificates or contracts at the cheduled rates of compensation as determined by the oard of Trustees of the Plan and to accept such rates s payment in full for eligible services. Under the UCR r Pace program, he accepts the amount allowed by he Plan.

The physician further agrees to abide by Plan Bylaws, Rules, and Regulations applicable to particiating physicians according to a copy which is available in the home office of the Plan.

Thirty days written notice of termination may be iven by either party but is not applicable to any ontract or subscription certificate in force at the time ntil the renewal date of the contract or subscription ertificate.

The Plan, therefore, maintains the right to unilatrally alter fee schedules and nonscheduled reimbursement levels. It also maintains the right to unilaterally mend the Bylaws, Rules, and Regulations applicable o the physician without prior or subsequent knowldge and/or consent of the physician or any actual otice to the physician.

It also should be noted that under the termination lause, the physician must continue to service subscripion certificates and contracts in force until their reewal. The same obligation is in place if the Plan ather than the physician initiates termination of the articipating provider agreement.

This analysis is informational only and is based pon the writer's review and opinion of the Blue Shield Agreement Form 176(4-82).

HOSPITAL COSTS

The cost of health care generally, and acute hospital care specifically, is a daily topic in all forms of the print and electronic media. Certainly DRGs, and especially the New Jersey version thereof, have captured a dramatic share of the headlines. Keeping the cost of health care within manageable ranges is a task that must be pursued.

However, parts of the problem cannot be solved by cost containment methodologies, since there are unusual elements involved which clearly are beyond the reach of the hospitals and physicians that are expected to affect cost containment.

Medicare is a real example of how the government is attempting to use cost containment to correct an eroding financial base when the erosion has been caused by external factors. The Medicare Hospital Insurance Trust Fund (HITF) is in trouble. Medicare Part A as we know it, is financed almost entirely from Social Security taxes, and current legislation prohibits the use of general budget revenues to make up any deficits between revenue and expenses. Payroll tax revenues must keep pace with the rate of increase in hospital expenditures to keep the Fund viable. According to government sources, hospital costs will rise at an average of 13 percent annually while taxable earnings are expected to grow at a rate of 6.8 percent annually. These projections illustrate the magnitude of the financing problem.

Congress dealt a devastating blow to the HITF in 1982, when it borrowed 12.4 billion from the fund surplus to address a deficit in the Old Age and Survivors Insurance Fund. That action reduced the HITF surplus from 18.7 billion to 8.3 billion at year end of 1982. Congress has made no provision for repayment of the borrowed funds.

To speak of cost containment is laudable. To be realistic, however, no form of cost containment outside of dramatic reductions in benefits will resolve the problems resulting from the above situations.

Medicare patients, hospitals, and physicians are in for hard times since it is a rule of political science that government will not accept the blame for its own mistakes. Physicians and hospital administrators should consider publicly speaking out against the impossible goal being presented to them by Congress.

AMA STATEMENTS

Incentive Grant Criteria for Traffic Safety Programs. The AMA commented on proposed rules implementing P.L. 97-364. The statement endorsed license suspension, jail terms, alcohol treatment programs, and increased enforcement as ways of reducing the number of drunken drivers. The AMA also endorsed providing supplemental grants to states that raise the drinking age to 21. (Statement to National Highway Traffic Safety Administration, January 24, 1983.)

Federal Election Commission. The AMA supported a provision in proposed regulations of the Federal Election Commission that would permit the political action committees of membership organizations to solicit families of members. This provision would grant to membership organizations the same rights that corporate and labor political action committees have had with regard to solicitation of family members. (Letter to Federal Election Commission, May 24, 1983.)

DEA Registration Fees. The AMA expressed its support for the Drug Enforcement Administration's proposal to increase the fee schedule for DEA registration of persons who manufacture, distribute, or dispense controlled substances. The Association indicated that the proposed fee schedule is reasonable in relation to DEA's cost of performing its important drug abuse control activities. (Letter to Drug Enforcement Administration, June 3, 1983.)

S-497 and S-503: "Look-Alike" Drugs. The AMA supported passage of legislation that would prohibit the creation, manufacture, distribution, or possession of an imitation controlled substance. The bills also would ban advertisements to promote distribution of imitation controlled substances. The Association stated that the bills would provide federal authorities with the tools they need to combat the look-alike drug traffic without interfering with the legitimate use of imitation controlled substances in research or by a practitioner as a placebo. (Statement to Subcommittee on Alcoholism and Drug Abuse of the Senate Committee on Labor and Human Resources, March 21, 1983.)

Health Care and Health Insurance for the Unemployed. In testimony before Committees of the House of Representatives and the Senate, the AMA addressed the national problem of unemployed persons who have lost their employer-based health insurance coverage, cannot afford to purchase private health insurance, and do not qualify for government health programs. The Association advocated the establishment of a temporary program that would provide limited health benefits to the unemployed, be administered in the private sector, and provide private insurance coverage with freedom of choice of provider. Financing should be shared between the government and the private sector. (Testimony to Senate Finance Committee, April 21, 1983, and to Subcommittee on Health and the Environment of the House Energy and Commerce Committee, April 22, 1983.)

Diagnosis Related Grouping (DRG). In a letter to HHS and key members of Congress, the AMA di cussed DRGs as a basis for reimbursement to hospita under Medicare. The AMA urged caution in conside ing any DRG proposal as this mechanism still is ur tried, and called for experimentation with differer reimbursement mechanisms in addition to the DR concept. (Letter to Department of Health and Huma Services, February 9, 1983.)

"Provider-Based" Physician Regulations. The AM submitted comments on regulations establishin criteria and maximum limits on reimbursement fc physician services furnished in institutional settings fc Medicare beneficiaries. In calling for the withdraw of these regulations, the AMA stated that elements c the regulations "are contrary to the provisions of §10 of TEFRA, and that they interfere with the practic of medicine. In addition, the methodology used fc computing the reasonable compensation equivaler (RCE) still fails to take into account appropriate dat and this methodology should be reconsidered." (Com ments to Health Care Financing Administration, Apr 1, 1983.)

Physician Assignment under Medicare. The AMA presented testimony on the issue of physician accept ance of assignments under Medicare. The AMA point ed out that "the medical profession has an exemplar history of treating Medicare beneficiaries on an assign ment basis. This is particularly impressive in light o the fact that the Medicare program has never reim bursed physicians at their usual, customary, an reasonable fee levels." The Association concluded tha the "overall record of physician acceptance of assign ment is a good one." (Testimony to Advisory Counci on Social Security, April 6, 1983.)

BUDGET RECONCILIATION: MEDICARE AND MEDICAID

The AMA recognizes that Congress and the Com mittee on Energy and Commerce (U.S. House of Rep resentatives) must confront the need to strike a balance between national expenditures and national income. Unfortunately, this does not necessarily mean a "bal anced budget" will result. Like the Congress, the AMA is concerned about the growing federal deficit. How ever, in considering reductions in federal spending, it must not be forgotten that programs like Medicare and Medicaid are designed to provide essential health care benefits to people and that individuals should not be made inadvertent victims of the budget process.

The AMA has testified before the Budget Committee's Task Force on entitlements and has cautioned against establishing unrealistic targets for savings in health programs that would result in limiting access to and the availability of health care for those individuals for whom the federal government has assumed a primary financial responsibility.

In creating the Medicare and Medicaid programs in 1965, Congress committed itself and the nation to

roviding access to high-quality care for the elderly nd the needy. To a large extent, that promise, has een met. The 17 years since enactment of those pro- rams have seen a tremendous improvement in the ealth status of these targeted populations. This is a esult of which Congress, the health care community, nd all Americans can be proud.

Nevertheless, the Medicare and Medicaid programs ave been the targets of a seemingly unending stream f recent cuts that have had federal budget consider- tions as their primary concern. These cuts have not een wholly appropriate as the increased costs and trains on the budget that have resulted from the rowth of the Medicare and Medicaid programs are ot attributable solely to problems with these pro- rams. The recession has added many individuals to he indigent rolls, and general inflation has "accounted or approximately 57 percent of the increase in total ystems cost (personal health care cost) for the period 971 to 1981 (*Health Care Financing Review,* March 983)." In addition, the population of individuals over ge 65 has been steadily increasing, and projections hrough the year 2030 indicate that this population will each 36,251,000 in 2000 and 64,925,000 in 2030.

The AMA does recognize that changes should be nade in government health programs in order to im- prove their efficiency and operation. No program hould escape scrutiny, review, or constructive criti- ism. The Medicare and Medicaid programs, however, lready have been the subject of major reductions dur- ng the fiscal 1981, 1982, and 1983 budget cycles. While here are further changes in those programs that we would support, we do not believe that the Medicare nd Medicaid programs should continue to be targeted or major cost cuts or major program restructuring nless there are adequate assurances that access to ppropriate high quality care will be available to eneficiaries of the program.

Freeze on Physician Reimbursement. The Adminis- ration proposes that physicians' reimbursement under he Medicare "reasonable charge" system be frozen for ne year. The customary and prevailing charge screens o be used for 1984 would not be updated but would e kept at the levels used in fee screen year 1983. This roposal would freeze the maximum amount of reim- ursement that Medicare would pay.

A freeze especially is unfair in light of continued cost ncreases that physicians must face in their practice nd for which Medicare reimbursement will be denied. s the federal governement now going to pay arbi- trarily undervalued prices set for 1983 to all suppliers f goods and services (and not just physicians under Medicare) in 1984? The answer obviously is no. The AMA believes that it is inappropriate for the govern- ment to freeze professional payments under Medicare while at the same time allowing payments under other programs to continue without a similar freeze.

The medical profession has an exemplary history of treating Medicare beneficiaries on an assignment basis. This particularly is impressive in light of the fact that the Medicare program never has reimbursed physicians at their usual, customary, and reasonable fee levels. The existing system where physicians have an option as to whether or not they will accept assignment has not resulted in beneficiaries facing substantial out-of-pocket costs as a result of physician charges above the Medicare recognized "reasonable" charge. It also must be remembered that the Medicare program was created as an insurance, not a welfare, program, and that a large number of Medicare beneficiaries are of substantial financial means.

Our research has shown that the primary reasons why claims are not accepted on assignment are administrative deterrents and inadequate reimbursement levels. The result of further reductions in physician reimbursement that would be caused by freezing any reimbursement increase for 1984 would be a further disincentive to acceptance of Medicare assignments. This could lead to increased costs to be borne by beneficiaries as the federal government further reduces its responsibility and the value of the program to the beneficiaries.

We urge the Committee to reject the proposal to freeze physician reimbursement under Medicare.

Catastrophic Coverage/Increased Copayments. The Administration proposes a new catastrophic hospital benefit with new copayment requirements for Medicare beneficiaries. All covered hospital costs would be paid by Medicare after 60 days of hospitalization each year. At present, Medicare hospital coverage expires after 150 days of hospitalization during a "spell of illness," with escalating patient copayments between day 60 and 150. However, the proposal would alter the current formula for beneficiary cost-sharing by providing for patient cost-sharing from day 2 to 60. The current first-day deductible would remain, but would be incurred no more than twice yearly.

The AMA supports catastrophic coverage for Medicare beneficiaries, with appropriate copayment during early stages of hospitalization. We are concerned, however, with the amounts of copayments proposed and the timing of their implementation. We believe that it would be more equitable for the additional copayments to be imposed later than the second day of hospitalization. We also note that the Administration's specific proposal requires copayments significantly higher than necessary to fund the costs of the additional catastrophic coverage. This would in fact transfer costs from Medicare to the beneficiaries either directly or through increased premium costs for supplemental coverage. A coinsurance adjustment that is not substantially greater than the cost of the catastrophic benefit would be more equitable. We urge the Committee to weigh these concerns in reviewing the Administration's proposal.

Part B Premiums and Deductibles. The Administration proposes to increase the premium for Medicare Part B to 35 percent of the costs of the program and

to index the Part B deductible. (A six-month freeze on the Part B premium was enacted in P.L. 98-21, the Social Security Act Amendments of 1983.)

The AMA supports this proposal, as it is in keeping with the original intent of the Medicare program. Originally, the program was to be funded one-half by general revenues. Medicare, like other insurance programs, should have appropriate front-end copayments and deductibles. We would recommend, however, that rather than tying the index of the Part B deductible to the overall consumer price index (CPI), the index should be tied to the medical care component of the CPI to reflect more accurately changes in the cost of medical services.

Medicare Eligibility. Under existing law a person is ordinarily covered by Medicare on the first day of the month in which he or she reaches the age of 65. The Administration proposes that eligibility for Medicare be deferred to the first day of the month following an individual's 65th birthday. The AMA does not support this proposed changed. It would be an inappropriate cost shift to the private sector and individual beneficiaries. This proposal would not create incentives to reduce health care costs.

Competitive Bidding. Under this proposal, competitive bidding for Medicare services would be expanded to include the purchase of laboratory services and certain other nonphysician services and supplies. While the American Medical Association does support competitive bidding for the purchase of certain supplies, we do not feel that this process is appropriate for the purchase of personal services related to the actual delivery of patient care. The practice of accepting a "low bidder" can result in the elimination of individual choice at a time when services that directly affect the individual may be involved. We strongly recommend that any attempt to bring competitive bidding into the provision of health care services be closely scrutinized and that this process only be authorized for the purchase of certain goods and not services.

Elimination of Deductible for Certain Laboratory Services. This provision provides that the Part B deductible would not apply to diagnostic services that are performed in a laboratory for which the Secretary has established a negotiated payment rate. The American Medical Association is concerned that this provision would have the effect of singling out one group of beneficiaries for different benefit levels. It could create situations where beneficiaries who do not have access to a laboratory with a negotiated rate would be forced to bear an increased cost in care. In our view, this provision would prove to be inequitable and we recommend against its adoption.

Medicare Vouchers. The Administration has proposed that Medicare beneficiaries be given the option of enrolling in private health insurance plans. The federal government would pay to the insurance plan chosen by the beneficiary an amount equal to 95 percent of the adjusted per capita costs of the Medicare program. Private plans would have to provide coverage at least equal to that provided by Medicare to be eligible. Beneficiaries who opt for the voucher plan would be permitted to reenter the Medicare system. If the private plan alternative costs less than the voucher amount, the beneficiary would be entitled to a cash rebate.

The AMA cannot support this part of the President's proposal. The concept of a Medicare voucher has been discussed over the last several years. Key questions about such a proposal are, of course, will it save any money and will it work? We believe that the lack of known answers to these questions is the reason why the proposal has not been accepted in the past.

Quite simply, nobody really knows what impact a voucher plan will have on beneficiaries and on the Medicare program. As the program currently is constituted, the health insurance trust funds do not pay out funds until an expense has been incurred. Under a voucher system, the program would pay a specific amount for each beneficiary who elects the voucher. This expenditure would occur prior to expenses being incurred for medical services. This type of approach can result in substantial savings only if those who elect the voucher system turn out to be the Medicare beneficiaries who use the greatest amount of services. If "regular" Medicare keeps all of the "bad" risks and the private coverage attracts only "good" risks, the voucher system could end up costing the government more, since the voucher amount will be determined on a percentage of the costs for Medicare beneficiaries who remain in the regular program. Due to this potential for adverse selection, the voucher program could face many of the same problems that recently have plagued the Federal Employees Health Benefit Plan.

It also is unclear whether a private insurer could compete with Medicare in light of Medicare's underpayment of physician fees and hospital costs. Medicare is reported to be purchasing hospital services at a 20 percent discount, and physician reimbursement is fixed at arbitrarily low levels. The full effect of the new prospective payment system based on diagnosis related groups (DRG) are unknown. Private insurers also are faced with costs that would be reflected in the Medicare 95 percent allocation.

While we do not support this provision as presented in the budget, we continue to support demonstrations and experiments with the voucher approach and urge Congress to direct that such experiments proceed.

The AMA realizes the complex and difficult task facing this Committee in reviewing the FY84 budget reconciliation instruction and the Administration's proposals concerning the Medicare and Medicaid programs. We are sympathetic with the need to reduce federal expenditures, but we are deeply concerned that inappropriate changes will result in individuals having to bear inappropriate increases in costs and possibly forego necessary care.

The AMA offered support for some provisions of he Administration's proposals that will have the effect f increasing cost consciousness in Medicare and Medicaid beneficiaries without causing serious impairment in the programs' ability to meet their intended urposes. However, we believe enactment of all cuts ecommended by the Administration seriously could essen the effectiveness of the Medicare and Medicaid rograms. They would deprive people of needed medial care, and break faith with those people who were romised that Medicare and Medicaid would provide ppropriate care.

TERMINATION OF HANDLING CONTROLLED SUBSTANCES

New Jersey Administrative Code 8:65-8.7

:65-8.7 Distribution upon discontinuance or transfer f business

(a) Any registrant desiring to discontinue or transfer business activities altogether or with respect to controlled substances shall return his Certificate of Registration, and any unexecuted order forms in his possession, to the Registration Branch, Drug Enforcement Administration, Department of Justice, Post Office Box 28083, Central Station, Washington, D.C. 20005 for cancellation. Any controlled substances in his possession may be disposed of either in accordance with Section 9 of this Subchapter or by transfer to another registrant. If the registrant desires to transfer the substance to another registrant, he shall take an inventory of all controlled substances which he desires to transfer and submit his inventory, together with his name, address, and registration number, and the name, address, and registration number of the proposed transferee, to the regional director of the Administration in the region in which he is doing business at least 15 days in advance of the date of the proposed transfer. If the regional director does not notify the registrant that the transfer should be postponed or cancelled, the registrant may transfer the substances to the named transferee without being registered as a distributor. All controlled substances listed in schedule I or II must be transferred pursuant to order forms in accordance to Part 305 of the Act. Schedule III, IV, and V substances will be transferred in accordance to the inventory prepared by the registrant and submitted to the regional director. If the regional director denies the registrant authority to make the proposed transfer, the registrant shall either dispose of the substance in accordance with Section 9 of this subchapter or transfer the substances to another registrant in accordance with this section and/or the instructions of the regional director.

(b) In the case of registrants required to make reports pursuant to Part 304 of the Act, a report marked "final" will be prepared and submitted by the transferor registrant showing the disposition of all the controlled substances for which a report is required; no additional report will be required from him, provided that no further transactions involving controlled substances are consummated by him. The initial report of the transferee registrant shall account for transactions beginning with the day next succeeding the date of discontinuance or transfer of business by the transferor registrant, and the substances transferred to him shall be reported as receipts of his initial report.

(c) A registrant shall notify the Drug Control Program, New Jersey State Department of Health, in writing no less than 15 days prior to the discontinuance or transfer of business activities with respect to controlled dangerous substances unless the program waives requirements in individual instances. Such notification shall include, but not be limited to:

1. Name, address, state CDS, and federal DEA registration number of registrant discontinuing or transferring his controlled dangerous substances activities;

2. Name, address, state CDS, and federal registration number or proof of application for same of registrants to whom the controlled dangerous substances are to be transferred;

3. Name, address, state CDS, and federal DEA number or proof of application for same of the registrant receiving the records, which include prescription files, or patient orders of practitioners of the discontinued business;

4. The name and address of the person or firm who will maintain business records, such as invoices, purchase records, and executed order forms of the discontinued or transferred business for a period of not less than two years; and

5. The date on which the discontinuance or transfer of business activity will take place.

(d) Upon the final date of discontinuance or transfer of the business activity with respect to controlled dangerous substances, the registrant shall return his state CDS Certificate of Registration to the Drug Control Program, New Jersey State Department of Health, Trenton, NJ 08625 for cancellation together with his federal DEA registration and all unused federal purchase order forms (DEA222).

HOUSE CALLS

The house call, as a traditional service, may reappear out of necessity as the health care field becomes more and more a "buyer's market." During 1982, 8 percent of physicians increased the number of house calls made. Five percent also have scheduled longer hours, and 22 percent have hired more nonphysician employees in order to improve service to patients.

The revival of the house call also could benefit certain patients both economically and medically, according to a study by the National Center for Health Services Research. The study, published in April, indicates that house calls by teams of health care pro-

fessionals could save as much as 10 percent in costs for the homebound chronically and terminally ill. Such patients, when treated at home by a team composed of a physician, a geriatric nurse, and a social worker, spent 38 percent fewer days in the hospital and 59 percent fewer days in nursing homes. The quality of care given at home was rated high by patients and their families.

PKU TREATMENT

Phenylketonuria (PKU) is an inherited disorder in which the body is unable to metabolize one of the amino acids—phenylalanine. This substance accumulates in the blood and damages the growing brain, causing mental retardation. There may be as many as 90 young people in New Jersey with this condition who are not under medical care.

If PKU is discovered in the first few weeks of life, the disorder can be treated successfully by giving the baby a special diet low in phenylalanine.

There is a screening test for this disorder which has been given to every baby born in New Jersey hospitals since 1965. Blood is taken from the baby's heel and sent to the State Department of Health Laboratory for testing. The disorder has an incidence of about 1:12,000 births and the number of children found varies from 7 to 12 per year.

Treatment for PKU can be found at Bancroft School, Haddonfield, (609-429-0100) and at United Hospitals Medical Center, Newark, (201-268-8763).

The State Department of Health now is working with New Jersey physicians to find all young people and adults who have been diagnosed early in life as having PKU and who are not receiving medical car for the condition. These people should get in touc with their physician or call one of the two PKU centers.

Developments in knowledge about PKU have mad it necessary to find all patients not under treatmen and to make sure they are reevaluated. This especiall is important for women with PKU who are consider ing becoming pregnant.

For information on PKU call one of the two center or the Maternal and Child Health Program of the Stat Department of Health (609-292-5616).

LOYAL SUPPORT

Scores of physicians quickly have responded t MSNJ's new Medical Action Committee (MedAC drive to improve medicine's participation in the legis lative election campaigns. MedAC will amplify ou ongoing state efforts, conducted through JEMPAC.

Within two weeks of our August 26, 1983, letter contributions to MedAC enabled us to raise our avail able campaign funds by more than 50 percent. Con tinuing response should make medicine a much more important force in state governmental action.

On behalf of all our members, President Alexande D. Kovacs, M.D., would like to thank the many who already have responded generously, and those who we are sure will join them.

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Physician-Owned Companies and New York Rate Rise

A perceptible swing in direction was apparent when the Physician Insurers Association of America met in San Antonio.

The physician-companies, many now completing six, seven, or eight years of operation, faced up to the reality of growing competition from commercial carriers as well as from specialty spin-off programs.

How much of a threat to existing policyholder bases this growing competition will prove to be and how to counter it were topics formally and informally discussed throughout the meeting.

The announced major move by the St. Paul Companies into California, a state in which three physician-companies linked to medical societies, an independent physician-company, and several trusts and exchanges already operate, was the most recent development to trigger concerns about competition.

"In the last year or so, St. Paul has entered or reentered a number of other states in direct competition with physician-owned companies, which were formed originally to fill the vacuum created when the commercial carriers walked away from the marketplace," keynoter David S. Masland, M.D., pointed out. Dr. Masland, chairman of the board of Pennsylvania Medical Society Liability Insurance Company, said, "How curious it is that the commercial insurance company giants would choose this time of skyrocketing underwriting loss ratios to expand or move into the industry's most volatile line of insurance."

According to Dr. Masland, commercial companies must pay agents and brokers to sell their products and those commissions sometimes are as much as physician-companies use to pay total operating expenses. Commercials also must generate profits for shareholders, while physician-companies operate on a not-for-profit basis, with one or two exceptions, and return excess funds to policyholders. "Yet commercial companies now seem willing to undercut physician-companies on price just to get a foot back in the professional liability door," he said.

Dr. Masland also cited moves by several medical specialty organizations to create their own professional liability programs: "The medical specialty route 'creams off' low-risk business, ignoring the long-term ramifications of an insurance program which, for the immediate economic advantage of any one specialty, ignores the intricate and necessary practice relationships that all medical specialties share with each other."

In the past year, the American Society of Internal Medicine launched a program for its members and so did the American College of Pathology. Five groups already have programs running, some dating back several years: American Society of Abdominal Surgeons, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American Psychiatric Association, and American College of Sports Medicine. Four other specialty organizations reportedly are looking into such programs.

"It goes without saying that if each of the low-risk specialties entered into an exclusive arrangement with a commercial carrier . . . no other single company would be willing, nor could it afford, to offer insurance to those other specialists who routinely are willing to perform high-risk procedures on patients referred to them by low-risk specialists," Dr. Masland emphasized. "Now there isn't a physician alive who is not smart enough to understand that rationale and yet many are willing to jeopardize medicine's long-term collective security for short-term economic relief."

As for St. Paul's decision to move into California, Dr. Masland theorized that a management decision might have been made "to use that group's enormous financial resources to 'squeeze' our physician-owned companies out of the picture through a deadly rate war which only a giant could hope to win if lower premiums are the only thing that practicing physicians really care about."

Dr. Masland said he believed that physician-companies were prepared to meet the competitive challenge but that success "will hinge upon how much reciprocity we enjoy, and I might say have earned, with the medical fraternity at large. We deserve that solidarity of physician support for our companies in the face of calculated cut-rate competition from the commercials, whether it comes at us head-on or disguised under the mantle of one of our own specialty society sponsorships."

The Pennsylvania physician chided physicians for "a lack of solidarity and for tunnel vision" in choosing a professional liability carrier as the marketplace heats up. The question at issue is whether dollars or loyalty to physician-companies will win the day, Dr. Masland implied.

Dr. James Todd, new PIAA president and chairman of the Medical Inter-Insurance Exchange of New Jersey, feels that physician-companies should have a competitive edge for several reasons: "Physician-companies ought to have a leg up in terms of credibility and trust. "These companies can maintain that they are doing a better job, with lower operating costs. They have resources available to them that neither commercials nor physician-companies linked to medical societies have."

On the proliferation of small-scale specialty programs, Dr. Todd said in his view, "Specialty groups are just too small to support a viable economic operation. If they really want to get involved, they should be working very hard to supply input to physician-companies. Why create a whole new program when the mechanism already is in place in many

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Director of Special Projects.

states?"

However, Dr. Todd said it will take a lot of selling for physician-companies to maintain that 50 percent or so of the medical market they have won.

Retiring PIAA president Ivan Neubauer, former chairman of the board, Norcal Mutual Insurance Company, feels that the California professional liability insurance situation presently is more stable than it has been in years, "In our favor is that most doctors are loyal to their own companies. The only action that PIAA itself has taken in response to a more competitive marketplace is to write all state medical associations inviting them to inform them about any entries into the field."

While some physician-companies express concern about stepped-up commercial competition, others say working relationships with such carriers in their states are good. Dr. James E. Davis, president of Medical Mutual Insurance Company of North Carolina, said, "We coexist very well with St. Paul and we are anxious that they stay in our state. We may have about 60 percent of the physicians insured in the state, but about 85 percent of the physicians are in private practice. St. Paul takes the medical centers, and that allows us to be more selective." (*Medical Liability Monitor,* Vol. 8, No. 6, June 29, 1983.)

MEDICAL LIABILITY INSURANCE RATE RISE IN NEW YORK

Increases averaging 25 percent in the rate New York physicians pay for medical liability insurance will be passed along to consumers and will add approximately $52 million annually to the cost of health care in the state, according to the president of the Medical Society of New York.

Richard D. Eberle, M.D., a Syracuse surgeon, said that enactment of liability reform proposals by the legislature "would have made it possible to avoid the rate increase, which will have to be passed along like all cost increases in our economy."

Dr. Eberle added, "The Senate passed a package of four bills which would have helped ease the situation but the Assembly did not go along, passing instead a bill which would have had little or no positive impact. Nothing went to the Governor for his signature. We appreciate the effort made in the Senate, especially by Senator Tarky J. Lombardi, Jr. (R-Syracuse), who argued forcefully for legislative action now."

The 25 percent rate increase, which became effective July 1, applies to policies written by the Medical Liability Mutual Insurance Company (MLMIC), which writes some 80 percent of New York's individual policies covering physicians. MLMIC's new rates for liability coverage are in the $50,000 range for physicians in certain high-risk specialties in certain parts of the state. Neurosurgeons practicing in Nassau and [illegible] Counties, in fact, now must pay $63,311 annually.

[illegible] physicians who are not insured by MLMIC have [illegible] the Medical Malpractice Insurance Association, whose rates are expected to go up at least as much [illegible] rates.

MLMIC [illegible] State Insurance Department in April for increases averaging 12 percent; MMIA for increases averaging 160 percent.

The New York Medical Liability Reform Coalition stated at the time of the rate request that liability reforms embodied in legislation sponsored by Senator Lombardi and Assemblyman William Bianchi would make it possible for the two insurers to forego the increases entirely.

Both insurance companies are members of the Coalition along with the State Medical Society, the Business Council of New York State, the Hospital Association of New York State, and other business, health, and insurance organizations.

The legislature recessed June 27, 1983, without taking action on the Lombardi/Bianchi bills (**S-2121, S-2122** and **A-4590, A-2497**), which could limit awards for non-economic losses to $100,000; mandate a contingency fee schedule for attorneys bringing medical liability suits; strengthen the process of pretrial screening; set criteria for expert witnesses; require attorneys to file certificates of merit; require periodic future payments for awards of $100,000 or more; and establish regional review and discipline boards to speed up the process by which charges of physician misconduct are investigated and resolved.

These reforms are needed, Dr. Eberle said, because "the whole area of medical malpractice litigation has gotten out of hand, not so much due to an increase in the number of cases—they are up just 34 percent from 1976 through 1981—but because the size of awards and settlements has skyrocketed—up nearly 400 percent from 1976 through 1982.

"The average award or settlement in 1976 was $35,970. In 1982, it was $114,768, and by 1990 or so actuaries estimate it will be $250,000."

Dr. Eberle added that, "Nearly 60 percent of all cases brought and concluded within the last seven years were found to be without merit, but insurers still were obliged to spend nearly $9 million in defending against those actions.

"Lawyers for the plaintiff ordinarily get one-third of the awards and settlements. That would be $83,000 of the typical 1990 award.

"Other expenses, including defense attorney fees, are paid separately, but still add to the tremendous cost of our system. It is so inefficient that the prestigious McGill Commission concluded in 1976 that no more than 25 percent to 40 percent of the money going into the medical liability system winds up in the hands of those persons who are injured through medical negligence and who require continuing care as a result."

Dr. Eberle pointed out that it is "not easy to make the case that the system is in trouble when those who oppose reforms focus exclusively on the fact that the insurance companies have what seem to be large reserves, and when the companies have been taking in more in premiums than they have been paying out in claims on a current basis. But our opponents overlook one important element of any company's balance sheet, its liabilities.

"In the case of medical liability insurance, the major liability is the fact that claims will have to be paid some years in the future with premium dollars collected today.

"Premium income is not used to pay claims that come due the year premiums are collected, but must be held to pay claims arising out of incidents which occur in that year. The lag time between the collection of premiums and the payment of claims covered by those premiums is about 8.5 years.

"We have one case which perfectly illustrates the point. The Employers of Wausau Insurance Company, which wrote its last policy here in 1974, still is paying and defending claims, and, so far, has exceeded reserves set aside for the purpose by nearly $135 million."

Dr. Eberle said that the State Medical Society will continue to "call upon the legislature to do what is necessary to save the medical liability system for those who truly need it, and to help hold down the rise in health care costs."

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HealthWays
THE WAY TO BETTER HEALTH CARE

Learning-Disabled Children, Schools, and Doctors

The changing focus of attention of physicians from sickness care to health care, from disease orientation to whole person, family, and community orientation, has influenced no specialties more than those dealing with children. For more than one medical generation, physicians caring for children have debated the contents, techniques, and procedures of the new pediatrics. Of all problems occurring in children, those involving how children behave and learn most exemplify these changes. On page 906 of this issue of *The Journal*, DeSpirito and Grebler describe their model association of pediatricians and other professional workers utilized to understand certain child developmental problems and to recommend remedial action. The popularity of the Jersey Shore Medical Center's clinic for the developmentally disabled and learning-disabled child is a mark both of the need for services for such children and the skills which DeSpirito, Grebler, and colleagues are able to provide.

There is no need to emphasize the usefulness of transdisciplinary teams in the understanding and management of developmental problems. There is a need to emphasize certain features of the function of these teams (now found in several centers in New Jersey) that DeSpirito and Grebler have not sufficiently brought forth.

(1) A single "evaluation" no matter how well done usually is not sufficient for long-term planning. It is only when a child's family and source of professional advice meet together over a period of time via a series of encounters that deep understanding may blossom and sensitive advice be available.

(2) For those children who are of school age (in New Jersey, under our latest legislation, this means handicapped children age 3 and over) the arena of action is in the school for as many of the waking hours of the day as in the home. Physicians who desire to be of help must be prepared to serve as advisors to schools as well as to families, while recognizing that their role is consultative and advisory, rather than authoritarian and commanding.

(3) Children and families find many sources of help of more or less value, one of whom is the medical advisor. The physician who desires to be of help must adjust to felt perceptions and wishes of families and patients while simultaneously remaining true to his or her body of professional knowledge and skill.

In this domain of health, a cure rarely is available, an alleviation of difficulty often is possible, but an understanding and coming to terms with what must be is necessary all too frequently. The art and science of coping with reality then becomes the dominant skill. Difficult though it may be, physicians must come to terms with the limits of medical power.

(5) Finally, the physician must meet at eye level in the marketplace with many other types of professionals, who often have distorted if not hostile perceptions of medical stereotypes and behavior. The physician is required to help other professionals work efficiently and effectively together, but as peers in collaboration. Often the team leader is not the physician, and often the center of action is far removed from health.

What are the special skills that physicians can provide for these children and families? They include, most often, one or more of the following:

(1) A sophisticated understanding of the influence of chemotherapeutic agents on behavior. Children with attention deficit disorders, seizures, or behavioral changes all may be aided by a program of chemotherapy which is integrated into behavioral, educational, social, and other forms of help.

(2) An awareness of the unity of mind and body, leading to a willingness to explore the reciprocal effects of, for example, chronic respiratory tract disorders, allergy, or other recurrent or chronic conditions on behavior and learning, and the reverse.

(3) Interpretation of health conditions and the effects of medication for parents, school, and other professional personnel who often have little background for understanding and may require extensive careful explanation. The result should help each clarify perceptions and deal more effectively with problems. Historically, physicians have served as definers of reality, and are looked to by large segments of the population for this purpose. The greatest satisfaction with physician encounters occurs when the person served perceives the physician as having explained clearly, in language intelligible to that person, what has happened to the patient, what is going to happen, and what can be done about it.

(4) The ability to analyze disturbances of neurologic function in the light of requirements for success at school and at home and to develop strategies by which adults, who must deal with a child, may lead the child to best use his or her abilities. This includes methods to reverse or break up dysfunctional reaction patterns sometimes utilized by children with developmental or learning difficulties. One common example might be the child with an expressive language disorder who, angered when he cannot successfully express himself in social situations, substitutes destructive behavior, temper outbursts, or other maladaptive responses.

(5) The development of a role as advocate for the child and for the family, to assist them in dealing with the great social systems (education, social service, administrative-legal) with which they must cope. This implies the subtle modulation of a role as mediator when the physician must serve the child, family, and educational system. An alliance may be required with each, simultaneously. It is most desirable that each develop the highest possible sense of competence and self-worth. Often the greatest value of the physician's intervention will be to break down destructive interaction and promote the most constructive possible relationships.

(6) A base knowledge about children and handicapping conditions that offers to all parties up-to-date, accurate, and scientific information. It is necessary to be able to describe what is known, and what is not known, and to acknowledge the limits of scientific awareness.

New Jersey physicians should be aware of actions taken by

the American Academy of Pediatrics, to increase the skills of the physician in practice. On a national level, the American Academy of Pediatrics, supported by a grant from the Bureau of Education for the Handicapped developed a postgraduate educational program on New Directions in Care for the Handicapped Child. The undersigned had the privilege of serving as cochairman of the Curriculum Task Force for this project. Thousands of physicians nationwide have taken this course to improve their skills.

On a state level, the New Jersey Chapter of the American Academy of Pediatrics, has formed a committee to prepare a course on the Handicapped Child for New Jersey pediatricians, in order to provide them with skills when consulting for public schools.

Ultimately, individual practitioners will need to consider both their interest in this field, and the competence which they have developed, to determine what their role will be. Physicians may provide primary health care, carefully screen their patients for developmental problems, and refer to others for more sophisticated diagnostic and therapeutic suggestions. Some pediatricians will be equipped to serve as consultants, and some community hospitals will provide teams for long-term diagnostic and therapeutic relationships. Finally, at a few major centers, a variety of subspecialists will offer in-depth analysis of unusual or particularly difficult diagnostic and management problems. We now have the basis for a coordinated network of primary, secondary, and tertiary resources, able at each level to provide the collaborative services which have been outlined above.

Avrum L. Katcher, M.D.

Dr. Bergen Reappointed

Stanley S. Bergen, Jr., M.D., has been reappointed as President of UMDNJ by the University's Board of Trustees. Dr. Bergen has accepted the assignment, which will run through June 1989. In the words of Stephen B. Wiley, chairman of the Board of Trustees, "Dr. Bergen has proved time and again to be an extraordinary leader, who has taken this very unique University from its raw beginnings to its present maturity and excellence. He has remarkable energy, insight, intelligence, and candor, and he enjoys the unanimous and enthusiastic support of the Board."

Dr. Bergen has been an active member of MSNJ, making regular contributions to the monthly meetings of the MSNJ Board of Trustees and to *The Journal* through his column which keeps readers abreast of some of the pertinent activities at UMDNJ.

Originally from Princeton, Dr. Bergen graduated from Princeton University in 1951 and received his medical degree from Columbia University College of Physicians and Surgeons, New York. He was a semiprofessional percussionist in those days. Postgraduate training in internal medicine at St. Luke's Hospital, New York, followed. Dr. Bergen is a Diplomate of the American Board of Internal Medicine and also is certified in clinical human nutrition. In addition to membership in the Essex County Medical Society, the American Medical Association, and the American Diabetes Association, he is a Fellow in the American Federation of Clinical Research, the American College of Physicians, the Endocrine Society, the Academy of Medicine of New Jersey, the New York Academy of Medicine, and the Association of American Colleges. Dr. Bergen also serves as a trustee of the Educational Commission of Foreign Medical Graduates and holds membership in numerous other professional organizations including the American Hospital Association.

As President of UMDNJ, Dr. Bergen is responsible for six professional schools (UMDNJ-New Jersey Medical School, UMDNJ-Rutgers Medical School, UMDNJ-New Jersey Dental School, UMDNJ-Graduate School of Biomedical Sciences, UMDNJ-School of Health-Related Professions, and UMDNJ-New Jersey School of Osteopathic Medicine). He also is responsible for the University Hospital in Newark and two community mental health centers.

Some highlights of Dr. Bergen's 12-year administration include:

- Achievement of university status for the then College of Medicine and Dentistry of New Jersey in 1981.
- Construction of the $200 million campus in Newark, featuring a medical science building, a dental building, a hospital, a library, and a community mental health center.
- Construction of medical education and research buildings in New Brunswick and Camden.
- Development of numerous specialty health care and research centers in New Jersey.
- Creation of the osteopathic medical school and the school of health-related professions.
- Development of the UMDNJ-Rutgers Medical School into a full four-year M.D.-granting institution and a center for specialized health care in central New Jersey.
- Expansion of the educational programs from a total enrollment of 556 in 1971 to more than 2,590 students in UMDNJ's six schools today, with more than 1,000 physicians in postgraduate training programs.



Stanley S. Bergen, Jr., M.D.

We congratulate Dr. Bergen and UMDNJ on this reappointment, which promises increasing progress in medical education and health care in the years to come. We applaud Dr. Bergen's active role in MSNJ activities and his concern for the health of New Jersey citizens. A.K.

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References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., when pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually recevving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients who se angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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"My daily routine consisted of sitting in my chair trying to stay alive."

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PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

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rocardia is indicated for the management of:
) Confirmed vasospastic angina.
) Angina where the clinical presentation suggests a possible asospastic component.
) Chronic stable angina without evidence of vasospasm in atients who remain symptomatic despite adequate doses of eta blockers and/or nitrates or who cannot tolerate these gents. In chronic stable angina (effort-associated angina) ROCARDIA has been effective in controlled trials of up to ight weeks' duration in reducing angina frequency and ncreasing exercise tolerance, but confirmation of sustained ffectiveness and evaluation of long-term safety in these atients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

Interdisciplinary Approach to Developmental Pediatrics in a Hospital-Based Child Evaluation Center

ANTHONY P. DeSPIRITO, M.D., and
JANICE GREBLER, M.S.W., Neptune*

Infants and children with suspected or confirmed developmental, emotional, and learning disorders with or without associated medical problems, require a comprehensive evaluation followed by recommendations of a treatment plan. The Child Evaluation Center at Jersey Shore Medical Center has provided these services since 1967. A review of 582 patient records from the period 1978 to 1981 shows that private physicians are the largest referral source and the hyperactivity-attention deficit disorder is the most frequent problem. We believe a community hospital-based center can provide the necessary professional services to families, physicians, and other referral sources in its area for such infants and children.

The current thrust of the interdisciplinary approach to developmental pediatrics is early identification and treatment. In recent years, numerous clinics have been established purporting to evaluate the developmental status of young children. Hospital-based evaluation centers, however, continue to be the mainstay for diagnostic evaluation of children at risk for developmental disability. These centers possess two distinct advantages: (1) availability of primary medical specialists, in addition to laboratory and [illegible] services, and (2) access and smooth transition from [illegible] and pediatric clinics of biologically vulunerable infant [illegible] children at risk for aberrant development.

This paper describes the services provided by the Child Evaluation and Learning Disabilities Center, a program which has been in existence at Jersey Shore Medical Center, Neptune, since 1967, and defines the demographic characteristics of the population it serves.

THE CHILD EVALUATION CENTER

Jersey Shore Medical Center, a private, accredited, and licensed nonprofit teaching hospital, is located in Monmouth County. The estimated population of Monmouth County in 1980 was 503,173, of whom 6.2 percent were of preschool age and 25.7 percent were of school age. The hospital provides clinical training of medical students and pediatric residents, and is affiliated with the University of Medicine and Dentistry of New Jersey.

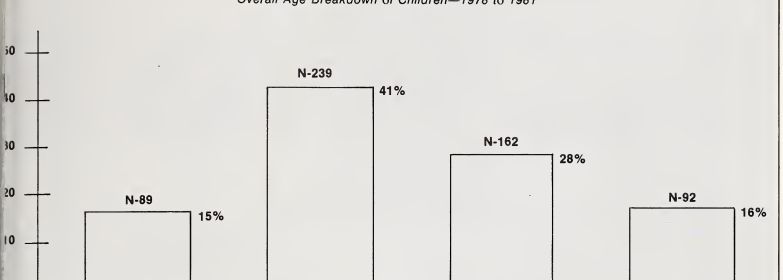
The Child Evaluation Center was established in 1967 under the direction of the Maternal and Child Health Program of New Jersey's Department of Health and was certified two years later by the New Jersey State Department of Education to evaluate handicapped children.

The purpose of the Center is to provide comprehensive diagnostic services for children with developmental, emotional, and learning disorders, through an interdisciplinary team, which includes a developmental pediatrician, a pediatric neurologist, a psychologist, a learning consultant, and a social worker. Ancillary medical services (otolaryn-

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TABLE 1

Overall Age Breakdown of Children—1978 to 1981



ologic, ophthalmologic, and endocrinologic), dental consultation, and speech and hearing evaluation are available.

The primary goal of the program is identification of the handicapping condition and formulation of a treatment plan. The Center's full-time graduate social worker functions as the clinical supervisor of the program and coordinates all professional activities. The social worker conducts intake interviews and a detailed developmental, medical, and psycho-social history is taken. After social assessment, the child is evaluated by a physician who will manage the case and order the necessary diagnostic studies as determined by parental concerns and the physical findings. The psychometric evaluation is performed routinely on all patients. The attending physician, or a designated member of the multidisciplinary team, conducts an interpretive interview to discuss the findings and proposed treatment plan with the parents, upon completion of the study. The social worker subsequently assists clients with implementation of the proposed treatment plan by making referrals as needed to community agencies.

RESULTS

The authors have gathered statistics by random selection of every third chart of the population through 1981. Between 1978 and 1981, a total of 1,746 patients were evaluated. This resulted in a review of 582 patient records.

Our patient population ranges in age from 0 to 18 years. The preschool children referred to the Center between 0 and 2 years generally have had a recognizable or diagnosed disorder at birth, while the children referred between the ages of 3 to 5 have not (Table 1).

Referrals to the program are accepted from outside agencies and professionals, and from parents themselves (Table 2). Media exposure of developmental and learning disabilities has stimulated parents to seek help from diagnostic and treatment programs such as ours. Parents of high-risk infants, in particular, are looking for assurance through ongoing developmental evaluations. The Center attempts to inform physicians, school personnel, and child care workers in the community through seminars presented by its professional staff and well-known experts in child development.

TABLE 2

Sources of Referral—1978 to 1981

Sources	No.	Percent
Private physician	189	32.5
Social agency	176	30.2
Parent	108	18.6
Head Start	61	10.5
Preschool	27	4.6
School	21	3.6

Physician participation in these programs has not been as high as attendance by other health professionals, but the highest rate of referrals is from private physicians. We believe that the high rate of child-oriented physician referrals is based on an awareness that the problems of the developmentally disabled and/or the learning-disabled child require thorough and accurate assessment before a plan of treatment is proposed. Physicians increasingly rely on the Center's professional staff to assist with the treatment plans of complex cases. Additionally, children who are treated with stimulant medication for hyperkinetic and attentive disorders are referred back to the Center by their physicians for periodic reevaluation and recommendations regarding adjustment in dosage. The neonatal specialists refer biologically vulnerable infants and young children for evaluation upon discharge from the Neonatal Intensive Care Unit's followup program. With the advent of the Neonatal Intensive Care Unit in 1967, there is an increasing trend toward appraisal of young children who are biologically vulnerable as a result of predisposing factors in the neonatal period. The main thrust has been evaluation of developmental lags and developmental disabilities. Table 3 summarizes the chief complaints of children referred to the Center between 1978 and 1981.

In recent years, there has been a strong trend toward assessment of the attention deficit disorder, with or without hyperactive behavior. There also has been an increasing concern about academic problems and learning disabilities. The most prominent complaint has been the combination of delayed language development and other developmental delay.

TABLE 3

Chief Complaint—1978 to 1981

Complaint	No.	Percent
Hyperactivity-attention deficit disorder	166	28.5
Delayed development	70	12.0
Delayed language development	109	18.7
Academic problems	102	17.5
Emotional problems (behavior, depression, autism)	55	9.5
Known mental retardation	40	6.9
Other medical problems	40	6.9

TABLE 4

Final Diagnosis—1978 to 1981

Diagnosis	No.	Percent
Hyperactivity-attention deficit disorder	140	24.0
Learning disability	132	22.7
Mental retardation	103	17.7
Primary behavioral disorder	84	14.4
Developmental lags	58	10.0
Other medical disorders	31	5.3
Serious psychiatric disturbance (autism, psychosis, depression)	34	5.9

Historically, since the Center's inception, rate of school referral has been low. The rationale for this is inherent in the legislative codes governing public education in New Jersey. NJAC 6:28-1.3 (b) mandates that "each local public school district shall employ basic child study teams in numbers sufficient to ensure provision of required services. . . ." Because of the availability of diagnostic services in the public and education sector, school referrals necessarily are limited to two categories, i.e. (1) referral by the school for second opinion and/or impartial evaluation by parental request, and (2) referral by a private school in cases where diagnostic services are not readily or easily accessible through the public sector. Parents of school-aged children often prefer the services of an outside agency (other than the school child study team) for the evaluation of learning difficulties.

Listed in Table 4 are the major final diagnoses. One should note that the majority of children diagnosed as learning disabled, by and large, have a reading disability. The diagnosis of "minimal brain dysfunction" sometimes is made for school purposes since classification of children in the state of New Jersey may require such a diagnosis to obtain special educational prescriptions. This diagnosis has been used in a number of children with attention deficit disorder [illegible] less either developmental lags or a learning disability. The value of such a diagnosis remains in doubt.[1,2]

[illegible] children with other medical disorders" include [illegible] seizure disorder, cerebral palsy, and orthopedic [illegible] abilities. Psychiatric disturbances include childhood [illegible] manic-depressive psychosis, and schizophrenia. [illegible] group of mental retardation, genetic syndromes are [illegible].

Specific recommendations are made after the needs of the individual child have been evaluated by the interdisciplinary team. Following each assessment, a proposed treatment plan is outlined carefully that is tailored to the individual needs of the patient. In some cases, team conferences are held to allow

TABLE 5

Recommendations—1978 to 1981

Recommendations	No.	Percent
Specific education recommendations	170	29.2
Preschool program	143	24.6
Medication	98	16.8
Guidance in management	88	15.1
Psychotherapy	46	8.0
Speech therapy	37	6.3

input from the various professionals who have examined the child.

Recommendations are made to the parents upon conclusion of the entire evaluation (Table 5). At this time, all of the testing results are discussed with the parents by one of the members of the team. The majority of the specific educational recommendations has been supplied by the learning consultant. Referral often has been made to an accessible mental health center or to private practitioners when psychotherapy is indicated. The results of the study of each child are given to the parents, to their private physician, and other sources, at parental request.

The large number of children with hyperactive behavior or the attention deficit disorder has stimulated an ongoing series of six-week seminars entitled "Behavior Management of the Hyperactive Child." This program, which has evolved as a mode of therapy for distressed parents, is held in the evenings in an attempt to involve the entire family. The first session is an individual review of learning disorders and hyperactivity. The five remaining sessions are conducted by a psychologist and involve parental education in the utilization of behavior modification techniques. This seminar has been a great help to parents.

SUMMARY AND CONCLUSION

The authors have described the services of a child evaluation center affiliated with a community-based teaching hospital. The hospital-based model is a logical approach to the diagnostic assessment of the "at-risk" child. Our medical center is equipped with all of the diagnostic resources required in an intensive study and has access to ancillary specialists and subspecialists. Secondarily, the medical center is depended upon by its surrounding communities for provision of essential health services. The continuity of care is reassuring; the followup of an at-risk child from the nursery through his or her academic career is preferable to the coordination of smatterings of reports from different and unrelated facilities. Furthermore, our type of program provides the opportunity for thorough longitudinal study.

Parents who seek a confirmatory medical diagnosis will turn to the center providing these services. This has been demonstrated by our referral source data which indicates that parents themselves frequently turn to the hospital-based model. Private physicians utilize the hospital-based child evaluation center with the assurance that each patient is referred back to the physician in the community for ongoing treatment.

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2. Hussey HH: Minimal brain dysfunction. *JAMA* 235:183, 1976.



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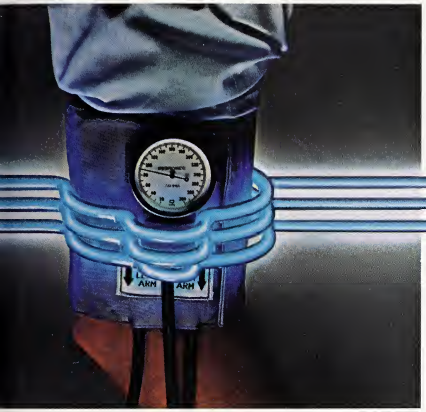
INDERAL LA offers the antihypertensive and cardiovascular benefits of INDERAL–with the additional advantage of convenient, single daily dosage. With a unique controlled-release formulation, INDERAL LA (propranolol HCl) provides sustained plasma levels and consistent, 24-hour beta blockade.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR.)

INDERAL® LA BRAND OF propranolol hydrochloride

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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inorotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curves (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval in most clinical settings. However, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour dosing on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic blockade have been utilized in dosages for example of 160 to 240 mg daily.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic activity is required for example if the heart has been severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade can prevent the necessary facilitation of impulse transmission across the myocardium. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache

efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride appears to be due to its ability to block a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in severe heart failure, if necessary, they can be used with close follow-up in patients with failure who are well compensated and are receiving digitalis and diuretics. The beta blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely. If failure continues, despite adequate treatment, INDERAL should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. These episodes have occurred after the administration of INDERAL should be gradually reduced, over a period of at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 propranolol.

PRECAUTIONS. General Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 300 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dose levels Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy: Pregnancy Category C INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular System. Bradycardia, congestive heart failure; intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory bronchospasm

Hematologic. agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Autoimmune. In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronies disease have been reported rarely. Oculomucocutaneous reactions involving the sclera, serous membranes and conjunctivae reported with a beta blocker (practolol) have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in sustained-release capsule for administration once daily If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL tablets. The INDERAL LA capsules do not produce lower blood levels Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 240 mg may be required. The time needed for full hypotensive response to a given dosage is variable and may range from a few days to several weeks

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained with dosage up to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use

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A Perinatal Program in a Community Hospital

WILLIAM J. FARLEY, M.D., and
PATRICIA T. BROWN, R.N., Point Pleasant*

The development of a regional perinatal program in a community hospital is presented and an eight-year study of neonatal mortality is reported. Data collection and regular study conferences permit a periodic review to upgrade maternal and infant care. Necessary ingredients of a regional system are good communication and collaboration of linked institutions.

This paper presents a statistical analysis of an eight-year study of the newborn service of a community hospital and comments on the organization and function of a perinatal program from the viewpoint of a sending hospital in a regional system.

PERINATAL STATISTICAL STUDY: RESULTS

In 1969, Farley described a perinatal study guide whose purpose was "to maintain optimal standards of maternal and infant care through the self-evaluation and periodic review of perinatal morbidity and mortality."[1] He outlined a format for use in New Jersey hospitals and encouraged regional conferences. The guide was simplified by the Child Health Committee of the Medical Society of New Jersey, endorsed by MSNJ, and recommended by the New Jersey State Department of Health for distribution throughout the state. It presently is being revised and updated.[2]

The initiation of regular quarterly Perinatal Study Conferences in the early 1970s by the combined obstetrical and pediatric departments of Point Pleasant Hospital provided an annual review of the maternal and newborn services. A complete tabulation of statistics was recorded for the period, 1974 through 1981.

Table 1 is a composite yearly study of 10,767 births. The number of births rose from 1,014 in 1968 (not recorded) to 1,428 in 1981, reflecting the population increase in the geographic area. The average incidence of low birth weight and very low birth weight infants of 5.0 and 0.6 percent has been below that incidence of 6.0 and 0.8 percent for whites in the United States.[3,4] Low birth weight infant deaths at Point Pleasant Hospital comprised almost two-thirds of all neonatal deaths; very low birth weight infants represented three-fourths of these, the major determinant of neonatal mortality.[5] The improvement in the care of these infants has been the principal factor in the reduction of neonatal mortality. It is impressive to note the decline in neonatal mortality rates (NMR) and perinatal mortality rates (PMR) at Point Pleasant Hospital in the past decade. The average NMR for the four-year period, 1968 to 1971, was 11.3 per 1,000 and for the period 1974 to 1981 was 5.4; the PMR for these periods was 23.6 and 13.6. For comparison, in 1978 the NMR in the United States was 9.4 and at Point Pleasant Hospital it was 3.5 per 1,000 live births.[6]

A review of the 28 inborn deaths revealed that 12 infants were less than 1,000 gm and 6 infants were less than 750 gm. Lethal congenital anomalies caused 10 deaths. The age of death was under one hour in 17 infants, between one to eight hours in 7 infants, and after eight hours in only 4 infants. Thus, most of the inborn deaths occurred within minutes in newborns who could not be stabilized for transport in spite of appropriate resuscitative measures.

Table 2 includes the number of infants transferred out of Point Pleasant Hospital to other institutions. The annual

*From the Maternity and Newborn Service, Point Pleasant Hospital. Correspondence may be addressed to Dr. Farley, 834 William Drive, Brielle, NJ 08730.

TABLE 1

Perinatal Statistical Review—Point Pleasant Hospital

	1974	1975	1976	1977	1978	1979	1980	1981	1974 to 1981
A. Perinatal Mortality									
Total no. births	1255	1200	1229	1356	1427	1442	1430	1428	10,767
Total no. perinatal deaths (live borns <501 gm)	25	15	14	17	20	19	19	13	142
Total no. stillbirths (>20 wks.)	12	6	7	10	12	10	10	5	72
Full size (>2,500 gm)	2	3	2	3	7	2	2	0	21
Low birth weight (<2,501 gm)	10	3	5	7	5	8	8	5	51
% Stillbirth to perinatal deaths	48%	40%	50%	58.8%	60%	52.6%	52.6%	38.5%	50.1%
Perinatal mortality rate (per 1,000)	19.9	11.7	11.4	12.5	14.1	13.1	16.8	9.1	13.6
B. Neonatal Mortality									
Total no. live births	1243	1194	1222	1346	1415	1432	1420	1423	10,695
Full size (>2,500 gm)	1166	1128	1165	1287	1353	1353	1354	1362	10,171
Low birth weight (501 to 2,500 gm)	74	65	57	58	59	76	61	61	511
% Low birth weight to live births	6.2%	5.5%	4.7%	4.3%	4.6%	5.5%	4.9%	4.5%	5.0%
Very low birth weight (501 to 1,500 gm)	13	6	3	5	7	10	5	9	58
% Very low birth weight to live births	1.1%	0.5%	0.3%	0.4%	0.5%	0.7%	0.4%	0.6%	0.6%
Total no. neonatal deaths (>500 gm and <28 days)	10	8	7	6	5	6	9	8	59
% Low birth weight to neonatal deaths	80%	62.5%	56.9%	33.3%	60%	66.6%	66.6%	62.5%	61.1%
% Very low birth weight deaths to neonatal deaths	50%	62.5%	28.6%	33.3%	60%	50.0%	33.3%	62.5%	47.5%
No. inborn deaths/ neonatal deaths (%)	6	5	3	2	3	1	5	3	28/59 (47.4%)
Neonatal mortality rate (per 1,000)	8.0	6.7	5.2	4.4	3.5	3.8	6.3	5.6	5.4

TABLE 2

Infant Transfers to Level III Centers

	1974	1975	1976	1977	1978	1979	1980	1981	1974 to 1981
Total No. Infant Transfers	15	20	26	32	36	42	38	39	248
% Transfers to total live births	1.2%	1.7%	2.1%	2.3%	2.5%	2.9%	2.7%	2.7%	2.3%
No. transfer deaths/ no. transfers (%)	4	3	4	4	2	5	4	5	31/248 (12.5%)
No. transfer deaths/ neonatal deaths (%)									31/59 (52.6%)

number and percent of live births has more than doubled, illustrating the increased utility of level III facilities. Of those infants transferred, 12.5 percent died at the referral centers. The number of neonatal deaths equally was divided between transfers and inborn deaths at Point Pleasant Hospital.

Birth weight and specific mortality rates are tabulated in Table 3. All 16 infants under 501 gm classified as live born (using the definition under New Jersey statutes N.J.S.A 26:8.1) expired. These infants were included in the perinatal mortality but not as neonatal deaths. A special category is suggested for those under 501 gm.

Increased survival with the increase in weight group is clearly is shown. A 75.7 percent mortality rate for the group 501 to 1,000 gm demonstrates their borderline viability

TABLE 3

*Birth Weight—Specific Mortality Rates**

Weight Group	1974	1975	1976	1977	1978	1979	1980	1981	1974 to 1981
<501 gm	3/3	1/1	0/0	1/1	3/3	3/3	5/5	0/0	16/16
	100%	100%	—	100%	100%	100%	100%	—	100%
501 to 1,000 gm	4/4	5/5	2/3	1/1	2/5	3/4	3/3	5/8	25/33
	100%	100%	66/7%	100%	40%	75%	100%	62.5%	75.7%
1,001 to 1,500 gm	1/9	0/1	0/0	1/4	1/2	0/6	0/2	0/1	3/25
	11.1%	0%	—	25%	50%	0%	0%	0%	12.0%
1,501 to 2,000 gm	2/10	0/15	1/9	0/13	0/6	0/14	0/5	0/11	3/77
	20.0%	0%	11.1%	0%	0%	0%	0%	0%	3.8%
2,001 to 2,500 gm	1/51	0/44	1/45	0/40	0/46	1/52	3/51	0/41	6/324
	1.96%	0%	2.2%	0%	0%	1.9%	5.9%	0%	1.9%
501 to 2,500 gm	8/74	5/65	4/57	2/58	3/59	4/76	6/61	5/61	37/511
	10.8%	7.4%	7.0%	3.1%	5.1%	5.3%	9.8%	8.2%	7.1%
>2,500 gm	2/1166	3/1128	3/1165	4/1287	2/1353	2/1353	3/1354	3/1362	22/10,171
	0.17%	0.27%	0.26%	0.31%	0.14%	0.14%	0.22%	0.22%	0.22%

*Values shown are number of deaths/number of live births with the percentage mortality in each weight group per year.

TABLE 4

Neonatal Mortality by Principal Cause

Cause of Death	1974	1975	1976	1977	1978	1979	1980	1981	1974 to 1981*
	10	8	7	6	5	6	9	8	59
Congenital malformation	2	2	2	4	2	1	5	1	19/59 (32.2%)
Immaturity	3	2	2	1	2	3	3	2	18/59 (30.5%)
Pulmonary dysfunction (RDS, meconium aspiration)	5	3	2			1		2	13/59 (22.0%)
Cerebral injury (asphyxia, hemorrhage)				1	1		1	2	5/59 (8.5%)
Infection		1				1		1	3/59 (5.1%)
Unknown			1	(SIDS)					1/59 (1.7%)
Autopsy rate %	80	62.5	85.7	83.3	100	100	100	75	87.1%

*Values in this column show the total number of deaths in each category/number of neonatal deaths with percentages for the eight-year period.

Autopsy rates also are tabulated.

especially of those infants under 750 gm. However, of 21 infants under 1,000 gm transferred, 13 infants survived with a mortality rate of 38.1 percent. Comparative rates for this group from several major centers ranged from 50 to 62 percent in 1975-1978.[3] Subdivisions of 501 to 750 gm and 751 to 1,000 gm are indicated. A rate of 12.0 percent for 1,001 to 1,500 gm infants is noteworthy. The combined rate for very low birth weight (VLBW), 501 to 1,500 gm, is (28/48) 48.2 percent. For the total low birth weight (LBW) group, 501-2,500, the mortality rate is 7.1 percent. Infants over 4,000 gm with their increased risk require future tabulation as a separate grouping.

The principal cause of death is recorded in Table 4, although several conditions might exist in any infant. Lethal congenital malformations (32.2 percent) and unqualified immaturity (30.5 percent) are the largest categories, comprising almost two-thirds of the total number. Pulmonary disorders accounted for 22 percent; they occurred most frequently in the years 1974 to 1976 when the need for early care and transfer may not have been recognized sufficiently. Asphyxia and intracranial hemorrhage occurred in five infants. Bacterial sepsis, cytomegalic inclusion disease, and a probable viral infection was found in three infants. One full-term infant died following discharge at 13 days of age with sudden infant death syndrome (SIDS).

The clinical findings and diagnosis were supported by an average autopsy rate of 87.1 percent for the total study period. The benefits of an expert postmortem examination for family counseling and for its educational value at quarterly conferences is stressed.

DISCUSSION

Morbidity data deserve equal time and should be collected for study. A knowledge of the incidence of hyperbilirubinemia, small- or large-for-dates infants, nonlethal congenital defects, types of infections, or other abnormal conditions may be translated into better care.

Sending hospitals require statistical feedback from referral centers. For instance, the number of maternal-fetal transfers is important information more accurately computed at the receiving center, for they may be transported from an obstetrician's office, from the outpatient department of a

referring hospital, or after admission to its maternity service. Computerized data processing will become a future necessity. In reviewing the national and worldwide medical literature, it is apparent that there is a need for clearer definition, and better uniformity of perinatal statistics. The interrelationship between the duration of pregnancy and birth weight is recognized and combined birth weight/gestational age categories for specific mortality rates are recommended.[3]

"The concept of regionalization of obstetrical and newborn services with the remarkable development of perinatal centers and neonatal intensive care units has resulted in a demonstrable reduction in mortality."

However, the accuracy of an assessment of gestational age often is questionable based on dates and may be difficult in brief increments based on the clinical evaluation of the sick infant by physical features and neuro-development.[8,9] Differences in ethnic and racial characteristics have less significance in our more heterogeneous society. The "secrets of Sweden" with its lower incidence of low birth weight infants (4 percent) and infant mortality rate are social and not genetic.[10] The disparity between white and nonwhite mortality rates has no biologic basis and separate tabulation may be abandoned except for sociological study. Expert committees on an international level such as the World Health Organization and through the Medical Society of New Jersey and the New Jersey State Department of Health are underway to improve the standardization and collection of equivalent data.[2]

THE COMMUNITY HOSPITAL REGIONAL PROGRAM

Point Pleasant Hospital is a general hospital in northern Ocean County with a maternity service of 22 beds, a nursery with 24 regular bassinets, and 10 incubators and intensive care bassinets. The hospital serves a lower middle class, white population. Private practitioners on the obstetrical and pediatric staff are all board certified or qualified including six family practitioners with limited privileges.

The concept of regionalization of obstetrical and newborn services with the remarkable development of perinatal centers and neonatal intensive care units (NICU) has resulted in a demonstrable reduction in mortality.[11,12] The Point Pleasant Hospital as a community hospital had the opportunity for maternal and infant transport to regional centers for specialized care. Infants initially were transferred to Monmouth Medical Center, a few to Philadelphia and later to the Jersey Shore Medical Center when that NICU was opened. Members of the pediatric department of Point Pleasant Hospital also have staff appointments at Jersey Shore Medical Center, Neptune, enabling them to maintain better lines of communication in the transport and care of infants sent to Jersey Shore Medical Center. The perinatologist and neonatologist of Jersey Shore Medical Center have consultation privileges at Point Pleasant Hospital which makes their advice more readily accessible. These factors have resulted in most transfers to Jersey Shore Medical Center since 1976.

For regionalization to be effective and efficient, medical and administrative cooperation between the perinatal center and its satellite hospitals is essential.[13] A referral center has an obligation to assist the sending hospitals in improving services, physical facilities, and equipment, and in providing a continuing educational program for medical, nursing, and technical personnel. Lectures and hands-on practical teaching sessions should be arranged, and periodic rotation of personnel through each institution is desirable.

The most frequent disturbing breakdown in relations is not in the provision of care but in the personal communication between patient, family, and professionals in each institution. Dealing with life-threatening problems with significant morbidity and mortality is not an easy task. Many individuals assist in the care of the high-risk mother and sick infant; therefore, parents and family may receive critical information from many sources. With the level of anxiety and guilt feelings normally generated, the utmost of tact and guidance is needed. A professional coordinator should be considered to provide responsible daily reports to parents and to attending physicians in the sending hospital, especially during the most acute period of care.

The New Jersey State Department of Health, upon recommendations of state planning agencies has endeavored to create area perinatal programs and to designate hospitals as to the level of care capable of providing mother and infant.[14] The number of deliveries per year has been used as an arbitrary criterion for level designation with the closure of smaller maternity units. It is estimated that at least 3 percent of pregnancies are high risk and require the services of a level III center and neonatal intensive care unit.[15] The percentage of live births transferred from Point Pleasant Hospital to a NICU has approached this figure (2.7 percent in 1981). The separation of mother and infant with the dislocation from the support of family and primary physician is an emotionally traumatic event to be avoided; therefore, joint transport of mother and infant should always be considered. The outstanding technological advances of obstetrical management and neonatal intensive care alone are not enough. The solution is the reduction of high-risk pregnancies.

Community hospitals with a level I or level II designation, as an integral part of a regional system, have an obligation to examine the population in the catchment area they serve for the demographic features and sociobiologic conditions that spawn most preventable perinatal problems and low birth weight infants. Level III centers in low socioeconomic urban areas obviously have a more serious commitment. The maternity services of smaller accessible outreach facilities, however, that provide total care for over 90 percent of pregnant women, have much to offer by way of active educational programs in maternal nutrition, natural childbirth, breastfeeding, parenting, and infant care and in the promotion of "wellness" in childbearing. Public health and social agencies must join in a cooperative effort. The plight of the teenage mother is an enormous problem. More effective health education in schools on substance abuse, sexual behavior, reproductive biology, prenatal care, and the positive aspects of responsible parenthood and family life must be encouraged. Although this subject is controversial, the attitudes of reasonable people, supported by those professionals interested in perinatal medicine, must prevail.

CONCLUSION

The community hospital should be an active participant in the regionalization of perinatal services. Regular study con-

erences permit the gathering of meaningful data and provide n excellent educational medium for the critical self-evalıation of individual case management. The primary prevenive care offered in a community-based setting to the vastly reater number of normal mothers and infants is no less xpert or less challenging than the more dramatic superntensive care of the relatively few sick neonates. Health rofessionals and consumer advocates have voiced concern or the continued expansion of sophisticated, impersonal ertiary care centers at the expense of health-oriented comunity "birthing" centers.[16] The ultimate goal should be the uccessful incorporation of the best ingredients of both. We lso place emphasis on the need to look beyond the doors of ach institution to identify problem areas and to minimize he inadequate and "costly role of health care in putting out ires rather than preventing the flames."[17]

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Cancer Prevention Study II

JOHN F.W. KING, M.D., Ho-Ho-Kus*

In September 1982, the American Cancer Society instituted a prospective epidemiologic study of environmental factors in cancer. With the aid of 100,000 Cancer Society trained volunteers in every state, 1,000,000 Americans will provide detailed environmental and lifestyle histories. Epidemiologists will assess data against a followup period of six years in an effort to define both causative and protective factors relating to cancer. In New Jersey, almost 6,000 American Cancer volunteers will recruit 50,000 participants for this study.

In 1959, Dr. E.C. Hammond and his associates on the national staff of the American Cancer Society instituted the first large-scale prospective study on the possible factors related to the causation of cancer. This was designated as Cancer Prevention Study I (CPS I). Five years earlier, Hammond and Horn, in their significant smoking and lung cancer study, discovered the effectiveness of trained volunteers in implementing the enrollment and followup on 168,000 men. Using the same resources resident in the volunteers of the American Cancer Society, Hammond enrolled and followed 1,000,000 participants for more than six years and, through death certificates on more than 70,000 individuals, the association between the causes of death and the data supplied in the 1959 questionnaires. Several thousand of these participants now are over 90 years of age and still are being followed to assess any factors that might be associated with protection against the risk of cancer.

Out of the data on one million persons studied, 450,000 bits of information were accessed and encoded and, to date, more than 50 articles have been published.

CPS I involved men and women and demonstrated associations with other diseases as well as cancer, including firm evidence on the relationship of smoking to heart disease. Some of the findings from this study included:

- Confirming the relationship between smoking and lung cancer.
- Firm evidence of the relation of smoking to heart disease, as well as to cancer in other organs, such as the mouth, larynx, pharynx, esophagus, and urinary bladder.
- An association of excess weight with certain cancers. Women 40 percent overweight had a higher risk of cancer of the uterus and ovaries; the same group had a slightly higher risk of breast and gallbladder malignancy. Men with the same excess weight factor had a higher risk of cancer of the colon, rectum, and prostate.
- Confirmation of the relationship between breast cancer and the history of the same disease in close female relatives and the lesser risk with higher parity.
- Frequent tranquilizer use was associated with a higher death rate as compared to that in nonusers. Antacid users showed a similar higher death rate, but frequent laxative users showed no relation to cancer death risk.

It was such prospective studies as the 1954 smoking study and the 1959 CPS I that provided the basis for the Surgeon General's Report of 1964.

PRESENT STUDY

In the more than 20 years' interval since CPS I, there have been changes in the exposures and lifestyles of many people.

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Changes in diet, use of medicines, artificial sweeteners, hair dyes, industrial exposures, and smoking habits have been notable. The type of "low tar, low nicotine" cigarette that was considered "low" in 1960, as a result of further refinement, was considered "moderate" in 1980; additional information is needed to determine whether or not the "new low tar/nicotine" brands are any safer.

Mr. Lawrence Garfinkel, who was associated with Dr. Hammond in CPS I, and who succeeded Hammond on his retirement as Vice-President for Epidemiology and Statistics at the national headquarters of the American Cancer Society, conceived the idea of CPS II to assess the effect of such changes in the lifestyles of the past two decades. He updated the previous successful questionnaire as a basis, and developed new CPS II questionnaires for men and women. Where the first study only enrolled about 25,000 black men and women, the new study hopes to enlist at least 100,000 black individuals among the 1,000,000 participants because of the evidence of higher cancer risk in this group.

The new study, which started in September 1982, again employs the proved technique of utilizing the ACS trained volunteers to implement the registration of participants and for the six-year followup described below. In the United States, 100,000 volunteers have been recruited to register the 1,000,000 persons to be studied.

METHOD OF STUDY

I. Selection of Volunteers: The state of New Jersey has been asked to enlist almost 6,000 volunteers to procure 50,000 participants. Our organization includes 21 county chairmen, 40 district coordinators, over 500 group chairmen, and over 5,200 volunteer researchers. Training sessions and written instructions are provided for each category in the volunteer organization, and the "researchers" are the keystone of the study.

The important job of the researchers is to identify at least ten families with whom he or she has some familiarity. An attempt will be made to recruit the members of such a family after the nature and purpose of the study has been explained to them. To those that accept, a numerically-coded but otherwise blank questionnaire will be provided by each researcher—a blue questionnaire for males, and a white questionnaire for females. With the questionnaire, each participant receives an envelope that bears the same numerical code; the participant is instructed to place the completed questionnaire in that envelope and seal it for confidentiality. No volunteer researcher or any other volunteer sees the completed questionnaire, and its privacy is insured until it reaches the researchers at the department of Epidemiology at the American Cancer Society, national headquarters. All of these sealed questionnaires were to be in the hands of the professional epidemiologists by the end of December 1982.

II. Selection of Participants: All participants must be over [illegible] of age, preferably in family groups; each family group must have at least one member over 45 years of age. A similar effort will be made to select families with participants in the 60s and 70s and to insure at least 10 percent black participants.

QUESTIONNAIRES

The male and female questionnaires, designed by the Project Director, Mr. Garfinkel, were based on the successful ones used in CPS I but modified to include additional information. Concise "check-off" questions are asked about age, weight, ethnic heritage, marital status, family history, medical and surgical history, including medical radiation exposures as well as any in occupation, habits, including smoking, diet, use of medications, occupations, religious, military service, and frequency of social activities. The female questionnaires ask for a detailed menstrual and reproductive history, the use and type of contraceptives, and information on the use of hair dyes. The male questionnaire has a more detailed history in the use of tobacco of different types. It is estimated that the careful completion of either questionnaire can be done in an average of 30 minutes.

FOLLOWUP

Every two years, for six years, each individual volunteer researcher will receive from the ACS researchers a computer print-out showing the name and address of each participant he or she enrolled. Beside each name, the researcher will be asked to indicate only three items of additional information, if applicable, any change of address of the participant; is the participant still living; and, if deceased, the place and date of death.

From this information, the epidemiologists will be able to consult death certificates and compare causes of death with information earlier recorded from their questionnaires. In the event a participant has moved to another part of the country, the request for followup data will be directed to another volunteer researcher in the area of the new address.

ANTICIPATED RESULTS

It understandably will take a few years before significant results can be published. During that period of followup and analysis, the associated volunteer researchers shall be provided with progress reports by the epidemiologists to underscore the importance of the followup phase. As soon as possible, progressive articles for the medical and scientific journals will be submitted.

SUMMARY

Present evidence strongly suggests that more than 80 percent of cancer occurrence has a significant environmental factor from our lifestyle, habits, and other exposures. Although smoking alone has been recognized widely as responsible for 30 percent of all cancer, many other factors that currently are arresting the serious attention of scientists require further definition or evidence. A prospective study of the environmental and lifestyle history of one million Americans now is underway by the American Cancer Society in every state and it has been designated as Cancer Prevention Study II.

The Medical Consultant's Role in Special Education Programming

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Physicians have significant involvement in educational evaluation and planning for handicapped students. To work most effectively within the educational context, physicians must understand and accept the educational process, the roles of school personnel, and the function of the child study team. The child study team process includes the physician in a set of roles: interpreter, consultant, supporter, child advocate, and counselor.

Physicians in New Jersey are expected to be involved in educational evaluation and planning for handicapped students. Yet, many physicians remain unfamiliar with the way public schools are organized and how school personnel function in providing services for their handicapped students.

The number of children classified as handicapped by the public schools of New Jersey in the 1981 to 1982 school year reached 13 percent of the total school population, or 156,693 children.[1] For each one of these students, a physician was involved with teachers and staff of a public school, in the process of referral, evaluation, classification, program, and placement. Beginning in September 1983, New Jersey public schools were mandated to provide educational services for preschool children ages 3 to 5 in addition to the school-aged population ages 5 to 21. Physicians assumed an even more significant responsibility for assisting school districts in identifying and evaluating this younger group of students. This article is written to assist physicians to understand better the medical consultant's role in the educational context, that they may communicate with schools more effectively and fulfill their responsibilities with greater personal satisfaction.

In working within the educational context, physicians must understand and accept the definition of handicapped student as it is used by public schools. New Jersey law defines students as handicapped if they "exhibit one or more handicapping conditions, (meaning) one (or more conditions) which impairs the pupil . . . to such an extent that special education and related services . . . are necessary to provide (the students) a free and appropriate education."[2] The handicapped student, by definition, is a student who cannot benefit from the regular educational program and must be educated, at least in part, in an adjusted or alternative setting.

Within the organizational structure of public schools in New Jersey, the educational process for the handicapped child is managed by a child study team. District child study teams function as an integrated part of a school's total system of operation. While the basic child study team includes, by state mandate, a learning disability specialist, a school psychologist, and a school social worker, other school personnel become involved in the identification, evaluation, planning, and programming for handicapped students. Professionals from outside the school's organization may become involved; a physician must complete a comprehensive medical evaluation for every child referred and evaluated.

The child study team functions to assist in the delivery of educational services. The concern is with methods by which schools can help the handicapped child in the ongoing and

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multidimensional process of growing, maturing, developing, and learning. Special education programming evolves from the identification and evaluation of specific needs. While it remains the responsibility of the basic child study team to determine a child's need for educational services, effective diagnostic evaluation depends on the observations and contributions of the physician as one of a team of professionals.

THE OBJECTIVE IS TO EDUCATE ALL STUDENTS

Education is a state function; the mandate is to educate all. In one sense, the reference is to each individual child who enters a school classroom, and while schools individualize instruction and programs, the mandate to educate all necessitates groups. A teacher's system for instruction and the school's system for education operate within the context of a group. Learning happens for the most part, for most children, in group situations. The school structure includes a curriculum that teachers are to teach and students are to learn; the curriculum is broken down into grades and adjusted by classes and by groups. The educational process is ongoing. It evolves on a continuum from kindergarten through high school graduation. The curriculum and experiences developed for one grade are dependent on the experiences of the grade before and determine the experience in the grades to follow. The educational process is multidimensional in terms of the integration of cognitive growth, social growth, and emotional growth. In any school, in any grade, in any classroom, and in any group the learners will be at different stages of development and at different levels of learning in one or all of these three dimensions.

When school personnel think about teaching children and plan for instruction, they focus on identifying an individual child's needs, but also make a diagnostic evaluation of needs for groups of children. Very seldom, if ever, is this a simple cause-effect situation. Teachers cannot say that if their diagnosis is X then the prescription is Y. There are too many variables and too many factors involved. The closest teachers can come to an "if X then Y" approach is to ask what are the variables? What is this child's dominant strength? What is this child's outstanding need? What are the variables for this group of children? What is their dominant strength as a group? What is their dominant need as a group? The questions have to be asked continuously and teaching must be adjusted continuously because children can change markedly in short periods of time.

THE OBJECTIVE IS TO EDUCATE THE HANDICAPPED CHILD

Public law requires that handicapped children be educated in a least restrictive environment. The term "least restrictive" means that a handicapped child is to be educated as much as possible with nonhandicapped students. Always, in the educational setting, there is the responsibility and the goal of relating an individual child's treatment to the social peer group, the classroom group, the school system, and the process. Special education, by law, must be an integral part of regular education.

The handicapped child in New Jersey is classified as having any one of a dozen or so handicapping conditions and is labeled accordingly. Developed over 20 years ago, the classification labels today serve primarily to categorize handicapped children for purposes of state and federal funding. Although the specific labels often prove somewhat arbitrary in terms of educational needs and programming, schools are required to deal with children within this classification framework. Regardless of what specific label is used, a handicapped child is a child who needs something in addition to or other than the regular classroom. A handicapped child is one who needs an alternative approach, teaching techniques, learning experiences, or materials that are different from what the regular students receive. The choices of alternative techniques and the special materials for handicapped students are many but, whatever choices are made, the educational process continues within the regular framework of a public school and still happens within a group structure and in a classroom environment.

A least restrictive program for one handicapped child might be the regular classroom with the regular classroom teacher making modifications to teaching techniques, providing supplementary materials, or adjusting expectations and assignments. For another handicapped child the least restrictive program might be a full-time special education classroom with mainstreaming for subjects as art and physical education with a regular classroom group. For a few handicapped children the least restrictive environment will be a private school or state facility. The question and the problem in planning and prescribing for a handicapped child is one of balance: how to serve a handicapped child's individual learning needs and still provide for the individual's social and emotional needs.

A HISTORICAL PERSPECTIVE

Only fairly recently have special education services existed within the framework of public schools. In the 1950s and early 1960s, very few special education programs were in public schools and, if they were, the self-contained special class was the dominant model. There were no resource rooms, supportive staff, or itinerant teachers except perhaps a speech therapist. Some schools did offer remedial reading and remedial math. The choice of retention as an option for giving a child additional time by holding him in a grade for a year existed only within the concept of failure. If a child stayed back, he failed. Of the special classes that did exist, most were for the educationally mentally retarded or the severely emotionally disturbed. These classes were in buildings outside the public school or in the basement of the public school, physically set apart from the mainstream. Often, it was only one person who decided that a child was in need of a special placement. This responsibility usually was delegated to the school psychologist. Parents were not involved and teachers were not involved.

Today the number of handicapped children in special programs in public schools has doubled. First, because children who were placed outside public schools or in the basement of public schools have been brought back to the mainstream; and second, because of increasing sophistication in diagnostic and prescriptive procedures. Educators have learned a great deal about mental retardation, learning disabilities, developmental lag, readiness, and the normal timetable for child development. They have learned about socially maladjusted and emotionally disturbed children, many of whom began to function much more acceptably when certain environmental adjustments were made. Learning behavior and social behavior can be modified without isolating a child in a special class full time. Within the public school setting, a team of educators representing many educational disciplines is involved with parents and other professionals in educational planning for the handicapped child.

Along with sophistication in identification techniques, public schools in the 1980s have a wide range of program

choices and placement alternatives for the handicapped child. With increased knowledge has come an extensive range of modifications that are possible within a regular class; teachers are becoming more sophisticated in making these modifications. With the increase of special education teachers and supportive staff members within the public school, regular classroom teachers are getting consultative services that enable them to assist the handicapped child in the school setting. Special education for handicapped children in public schools today involve a number of alternatives and a number of educational specialists. Special education involves teaching equipment, special teaching staff, and the child study team for the purposes of diagnostic evaluation. Special education involves parents and the medical profession.

THE PHYSICIAN'S LEGAL ROLE IN EDUCATIONAL PLANNING

Public law 94-142 is the federal umbrella law governing special education for handicapped children in the public schools. The New Jersey Administrative Code Title VI defines, in specific terms, the rules and regulations that govern the process in this state. Legislation addresses such issues as rights to privacy, due process, time limits for evaluation, procedures for writing individual programs, and guidelines for implementing those programs. The laws for the educationally handicapped are under scrutiny at present and soon may be changed; but, regardless of any change in rules and regulations at the federal level or at the state level, public education for handicapped students is here to stay and special education students will continue to be serviced across many disciplines in the public school setting.

Every school district must have a school physician to work closely with the basic child study team. Legally, the role of the school physician in the child study team process is to ensure that every handicapped child receives a comprehensive health appraisal as part of his/her diagnostic evaluation. Clearly stated in the code is the responsibility of the school physician to include a summary addressing the educational relevance of the medical findings and the impact of any "health management" plan on the pupil's learning processes. Any evaluations completed by a child's private physician are required legally to be reviewed by the school physician. The child study team alone determines a pupil's eligibility for special education or related services, but the team must act in consultation with a school physician. Child study teams are to make decisions on whatever recommendations a physician asks them to consider. Their decisions about classification and educational programming include input from many disciplines. Physicians and the medical profession are an important part of the total process.

THE PHYSICIAN'S PERSONAL ROLE IN EDUCATIONAL PLANNING

How much time the physician spends with the child study team and the extent to which the physician becomes involved with the evaluation and programming process, varies among districts and according to the individuals involved. However, there is a set of roles which both child study teams and physicians have found valuable, if not imperative, for effective educational planning for handicapped children.

1. The physician's role should be an interpretive one. Physicians need to have input into the child study team diagnosis of a handicapping condition, which means that the medical examination is one of several examinations that must be considered. The child study team needs to be able to relate the medical evaluation to their educational evaluations.

2. The physician's role should be a consultative one. Physicians can respond to medically related questions that the child study team must address. Is there a medical problem? Is it affecting learning? Is there enough of a medical problem and is it affecting learning enough that it needs to be paid attention to in school? How is the medical problem likely to affect school functioning? How is medical treatment likely to affect school functioning?

3. The physician's role should be a supportive one. Physicians can support the school's effort to evaluate children from many perspectives by understanding and accepting the educational objective. The school is interested in the support physicians can give to parents in terms of increasing parent awareness of the child's development and the school's objectives.

"A handicapped child is one who needs alternative approaches, teaching techniques, learning experiences, or materials that are different from what the regular student receives."

4. The physician's role should be one of communication. Physicians can facilitate the educational process by keeping communications open with parents and with school personnel. The school appreciates the value of the physician-patient relationship in building trust between the parent-child/patient and the school. If parents perceive the physician and the school as working together, communication is more likely to be open, honest, and consistent.

5. The physician's role should be one of child advocate. Physicians who know the medical history, the school history, and the child's family background can call attention to issues, raise legitimate questions, clarify differences, and negotiate workable resolutions. Both parent and school can benefit from the physician's alliance with the child apart from the often emotional involvement of family members and school personnel.

6. The physician's role should be one of counselor for parent and child and for school staff. Physicians often can offer meaningful support to those who must handle the child with learning difficulties on a daily basis. The process of referral and diagnostic evaluation usually is a time when anxiety is high and patience tenuous. The process of educational planning can be confusing and frustrating, and the implementation of specific recommendations difficult. Living and working with a handicapped child can be physically and emotionally draining for parents and teachers.

SELECTING AN APPROPRIATE EDUCATIONAL PROGRAM

A legitimate comparison might be made between the school's process of planning for special education programming and the physician's planning for a drug or treatment plan for his patient. The significant questions are the same: "What will happen if I prescribe this particular medicine?"; "What is the greatest need of this patient?"; "What are the

side effects of my treatment plan?"; "How much do I prescribe in order to balance the need against the side effects?" For the handicapped child in the educational setting the same concerns are raised: "What will happen if I prescribe this?"; "What is this child's greatest need?"; "Where should I begin?"; "What do I address first?"; "How much special treatment?"; "How extensive an educational program do I give this child and still balance the possible side effects socially and emotionally and sometimes even cognitively?"

If too much time in the school day is spent learning to read or training fine motor skills, the child may lose opportunities to develop broad concepts of science and social studies, for example, which do not necessarily depend on reading or writing. A physician might decide to prescribe a large dose of a powerful drug for quick response, as long as the patient can tolerate the side effects. With smaller doses over a longer time, there would be fewer side effects or perhaps the patient can learn to live with them. A physician may select no medicine or no treatment because the risk is too great or because time itself might provide the cure or solve the problem. Educators choose from a comparable view of "therapies" when they prescribe a program or a treatment for a handicapped child.

"The role of the school physician in the child study team process is to insure that every handicapped child receives a comprehensive health appraisal as a part of his/her diagnostic evaluation."

Education choices are made within the framework of an obligation to provide a special education program to meet specific needs but within the least restrictive environment possible. A very restrictive program might be recommended in the hopes that remediation of specific learning deficits will happen sooner, but it is necessary to consider whether or not the child can tolerate, socially and emotionally, such a restricted environment. Consideration might be given to a less restrictive program over perhaps a longer period of time, working toward remediation with fewer side effects, for cognitive, social, and emotional growth, with the hope that the child will learn to control or to cope with his particular learning problem. A third choice would be to prescribe no particular special education program; to keep the child in a regular classroom with some in-house or in-classroom modification for teaching with the belief that time itself might solve or cure the problem.

The child study team may or may not decide that the physician's specific recommendations educationally are needed. Physicians must keep in mind that the child study team serves the handicapped child in the educational setting and from an educational framework, not a medical one. The decisions and the recommendations they make for a handicapped child are bound by law to be educationally relevant and educationally appropriate. Even though a physician's recommendation unquestionably would benefit a child, the child study team is in a position and is mandated to clarify whether or not the medical recommendation is an appropriate instructional need. What the child study team ultimately determines for a handicapped child must be based on having received input from all sources: from the child, from the parent, from the teacher, from observation, and from evaluations as well as from the medical profession. In the final analysis, however, it is the basic child study team who decides whether or not a child receives services and exactly what those services should be.

Clarification of appropriate educational program and instructional services is not an easy one to make and, in fact, many of the questions now being raised about public school services for the handicapped student involve these types of decisions. There are no easy answers. Whatever the child study team determines to be an educational need must be written into the individualized education program (IEP). A child's IEP spells out specific goals, objectives, and services required to insure delivery of an appropriate educational program. The school is bound by law to implement the IEP and the taxpayer is bound by law to pay for whatever programs and related services are required for a student to benefit from the educational program. Education for the handicapped child must be free and must be appropriate. If a hearing aid, vision training, physical therapy, occupational therapy, speech and language therapy, adaptive physical education, psychiatric services, counseling services, or transportation services are written into a child's IEP as being needed for the child to benefit from an educational program, then the school must provide those services. The handicapped child is entitled to an educational opportunity equally with the nonhandicapped child.

CONCLUSION

Special education for handicapped children has changed dramatically since the 1950s. It still is changing and will continue to change as schools become more sophisticated in their approach, as schools become more skilled in teaching, and as questions and issues are raised, discussed, and resolved.

The job of the public school system is to consider the needs of the handicapped child as an individual, but also as a person who lives with, relates with, and learns with groups of other individuals. Balance of a multitude of needs, judgments about many variables, input from a multitude of sources, and consultations with specialists from a variety of perspectives are the essential components of doing this job well. The handicapped child is not an isolate and does not live and learn independently of anything else. The mandate for public education is to educate all and to educate each according to need. Physicians are part of the child study team process. The focus is the child, the workplace is the school, and the efforts are cooperative.

The child study team process in the educational context calls on each participant as a citizen who supports the concept of public education, as a professional who contributes a specific expertise, and as an individual who cares personally about the success of the children the school is working to serve.

REFERENCES

1. New Jersey State Department of Education: *Special Education. A Statistical Report for the 1980-1981 and 1981-1982 School Years.* Trenton, NJ, September, 1982.

2. *New Jersey Administrative Code,* Title VI, Subtitle F, Chapter 28 (6:28-1.2).

INTRODUCING
THE

TO COUNT ON

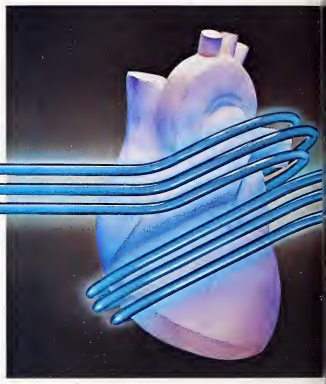
NEW

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES



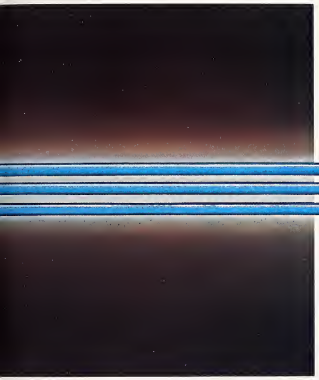
THE ONE TO COUNT ON FOR THE EXPERIENCE OF INDERAL—

A unique controlled-release formulation offers effective 24-hour beta blockade

Regardless of pH or contents in the GI tract, INDERAL is diffused from small spheroids at a controlled and predictable rate.

Providing clinical results equivalent to tablets

In controlled clinical studies, a single daily dose of INDERAL LA provided the same therapeutic response as equivalent doses of conventional INDERAL tablets. While there is little correlation between plasma levels and clinical effect in hypertension and angina, blood levels achieved with INDERAL LA are usually lower than those achieved with an equivalent mg dosage of conventional INDERAL due to differences in hepatic metabolism.



THE ONE TO COUNT ON

WITH ONCE-DAILY DOSAGE

In hypertension, angina, and migraine

Smooth 24-hour control

Unsurpassed simplicity and convenience

Single daily dosage for enhanced patient compliance

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

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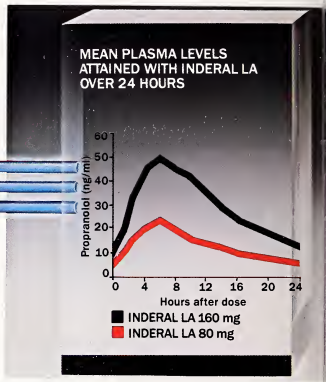
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NEW

ONCE-DAILY

INDERAL® LA

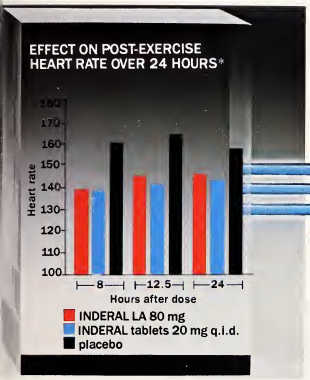
(PROPRANOLOL HCl) LONG ACTING CAPSULES



THE ONE TO COUNT ON FOR SMOOTH PLASMA LEVELS—

Sustained plasma levels

In pharmacokinetic studies, blood levels with once-daily INDERAL LA were found to be adequate to maintain sustained clinical effect throughout 24 hours. The unique controlled-release formulation of INDERAL LA minimizes differences between peak and trough plasma concentrations.



THE ONE TO COUNT ON

AND 24-HOUR BETA BLOCKADE

Provides therapeutic benefit throughout the day and night

In placebo-controlled trials, INDERAL LA was found to provide sustained 24-hour beta blockade as measured by decrease in heart rate, systolic blood pressure, and rate-pressure product. Patients taking once-daily INDERAL LA receive continuous protection from dose to dose–with therapeutic response equivalent to multiple daily doses of INDERAL tablets.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a trademark of Ayerst Laboratories.

*INDERAL LA vs. tablets: N.S. at all hours measured.
*INDERAL LA vs. placebo: $p<.05$ at all hours measured.

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NEW

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES



THE ONE TO COUNT ON FOR INITIAL THERAPY IN HYPERTENSION

Start with 80 mg once daily

The usual initial dose is 80 mg INDERAL LA whether used alone or with a diuretic. Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control.

When converting patients from other beta blockers including INDERAL tablets, start with the nearest milligram equivalen of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary.

Unsurpassed convenience and simplicity

Enhanced patient compliance



THE ONE TO COUNT ON

AND ANGINA

Simplified core therapy begins with 80 mg once daily

Although individual patients may respond to various doses, the average optimal dose in angina pectoris is 160 mg once daily.

Compatible with other conventional antianginal therapies

The experience and protection of INDERAL

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

ONCE-DAILY

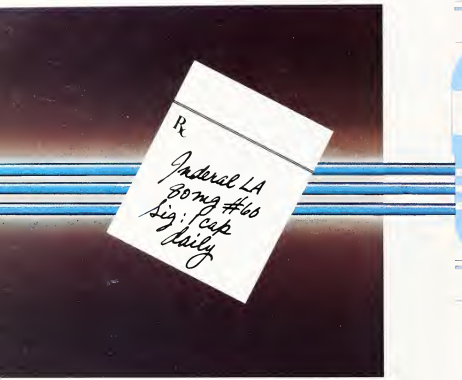
INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



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THE ONE TO COUNT ON

THE ONE TO COUNT ON FOR THE EXPERIENCE OF INDERAL NOW WITH ONCE-DAILY DOSAGE

In hypertension, angina, and migraine—start with 80 mg once daily

Smooth 24-hour control

Unsurpassed simplicity and convenience

Enhanced patient compliance

Three strengths for prescribing convenience

For arrhythmias, use conventional INDERAL® tablets

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES

Ayerst®
AYERST LABORATORIES
New York, N.Y. 10017

Please see last page for Brief Summary of Prescribing Information.

ONCE-DAILY INDERAL® (PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg 120 mg 160 mg*

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

INDERAL® LA brand of propranolol hydrochloride

(80 mg, 120 mg, 160 mg Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When administered at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can precede effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing ventricular fiber length, end-diastolic volume and systolic pressure during the period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The relative importance of the antianginal effect of propranolol which has been established beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity may be harmful. The beta receptors are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which increases the force of the antianginal effect of propranolol is greater than first degree. beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial consnction by interfering with adrenergic bronchodilator activity which may be of no consequence in persons subject to bronchospasm.

Propranolol is not significantly dialyzable

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension. It may be used alone or concomitantly with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced dyspnea, angina, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma: 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulation in patients with congestive cardiomyopathy and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients who do not have a history of heart failure and with digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) – PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug related tumorogenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block, hypotension, thrombosis of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place; short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous: alopecia, LE-like reactions, psonasiform rashes, dry eyes, male impotence, and Peyrone's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval

HYPERTENSION – *Dosage must be individualized* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS – *Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS)

MIGRAINE – *Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks

HYPERTROPHIC SUBAORTIC STENOSIS – 80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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New York, N.Y. 10017

Update on the New Jersey State Cancer Registry

ANNETTE STEMHAGEN, D.P.H., and
ADDISON E. TALIAFERRO, M.P.H., Trenton*

The New Jersey State Department of Health Cancer Registry Program has released its first incidence report. A summary of the Registry's procedures and goals is presented together with data describing New Jersey's cancer incidence in 1979.

The New Jersey State Cancer Registry is a population-based incidence registry established for the purpose of evaluating the impact of cancer in a defined population, i.e. the state. The Registry data system is designed for the collection, management, and analysis of data on persons with all malignant diagnoses as well as some specified borderline and benign diagnoses. The major source of case reports is New Jersey hospitals, although reports also are received from independent clinical laboratories. Physicians and dentists are required to report cancer cases not referred to or previously diagnosed in a New Jersey health care facility. The basic source of information is an abstract of information from the patient medical record. The collected information includes demographic data on each patient and medical data on each cancer. No information is included on modes of treatment or on survival, and the only followup information included is date of death.

The objectives of the Cancer Registry Program are:

1. To provide data on cancer incidence in New Jersey by age, race, sex, and location for use in planning and evaluating cancer prevention and control activities.

2. To provide data for identification of high-risk groups and occupational patterns of cancer occurrence.

3. To facilitate and promote studies related to cancer prevention and treatment by establishing a cancer patient data base.

Cancer was made a reportable disease in New Jersey on October 1, 1978, under statute N.J.S.A. 26:2-104-109. The first incidence statistics from the State Cancer Registry have been compiled.[1] These data describe cancer incidence in New Jersey for 1979, the first full year for which incidence data were collected. Up until this time, the cancer experience in the state could be categorized only by mortality information.

The Cancer Registry identified 27,557 incident cancer cases diagnosed in 1979. Of this total, 49 percent were among males, and 51 percent were among females. Figure 1 shows the major causes of cancer incidence in the state. By specific primary site, the leading causes of cancer incidence among New Jersey males in 1979 were cancers of the lung, prostate, colon, bladder, and rectum. Cancer of the breast was the most common type of cancer among New Jersey females. Cancers of the colon, cervix uteri, lung, and corpus uteri ranked second through fifth in relative frequency of occurrence.

Data for only one year are not sufficient either for the analysis of trends or for the determination of geographic patterns of high rate areas. However, we were able to

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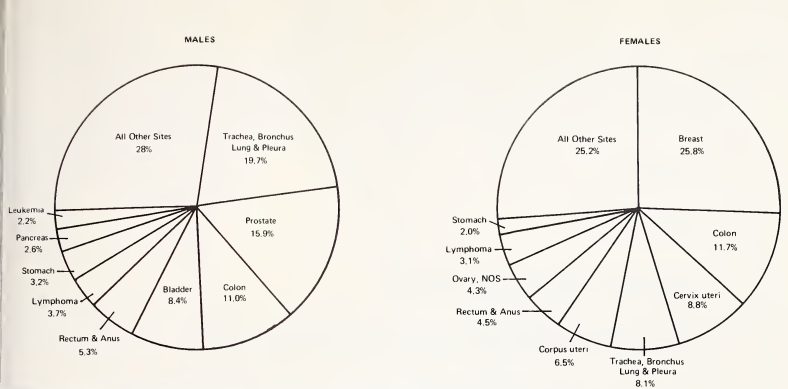


Figure 1—A listing of the major causes of cancer incidence in this state.

compare 1979 rates for New Jersey with national data published by the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute for the period 1973 to 1977 (Figures 2 and 3). The SEER Program includes 11 population-based registries throughout the United States and represents slightly more than 10 percent of the United States population. Any variations in rates may be a result of the differences in time periods between the two data sets or they may reflect actual differences in risk. Data from New Jersey were compared with SEER only to provide a rough comparison of the magnitude of the two rates. Standard errors for SEER data were not available, and consequently no statistical tests were made to determine whether any of the New Jersey-SEER differences were statistically significant. For cancer sites with low incidence, New Jersey data for one year may be somewhat variable and may not be the best estimate of true incidence.

The total male cancer rate for New Jersey males, 405.2 per 100,000, was higher than the rate of 384.4 for males in the SEER areas. The female rate in New Jersey was 320.1, lower than the SEER rate of 351.6. Within major site groupings, the greatest difference in rates for males occurred for cancers of the urinary system. The rate for New Jersey males was 45.0 per 100,000 while the SEER rate was 37.1. Rates for New Jersey males were lower than SEER rates for cancers of the endocrine system and for multiple myeloma. For females, the greatest difference between New Jersey and SEER rates for major site groupings was for cancers of the female genital system. In particular, incidence rates for cancers of the cervix uteri and corpus uteri were lower among New Jersey females than among females in the SEER areas.

A particular problem with a population-based registry such as New Jersey's concerns the reporting of diagnosed cases from out-of-state sources and those cases never hospitalized for their cancer diagnosis. We believe the first area, out-of-state diagnoses, may be a particular problem in the populations in the northeastern counties of New Jersey who may be diagnosed in New York City. Although we do have a reciprocal reporting agreement with the New York State Cancer Registry, New York hospitals do not always report cases occurring among New Jersey residents to the New York State Registry. We are working to correct this problem. The second reason for incomplete case ascertainment, the identification of cases who never were hospitalized in New Jersey for their cancer diagnosis, can be resolved by active physician participation in reporting cancer cases. Registry staff gladly will assist in any way possible to identify cases which should be reported.

The first analysis of cancer incidence in New Jersey includes data for major cancer sites at the state and county levels. As additional years of data become available we plan to expand the scope of our annual report to include data for municipalities and to evaluate information on specific age and racial groups.

The success of the New Jersey State Cancer Registry is dependent upon the work of New Jersey hospitals, laboratories, physicians, and dentists in reporting cancer cases to us. We would like to express our appreciation to all who have worked with us to develop the ideas and to implement the procedures for a statewide incidence registry in New Jersey.

SUMMARY

The New Jersey State Cancer Registry is a population-based incidence registry established for the purpose of evaluating the impact of cancer in the state. A summary of incidence data and of the methods used by the Registry to identify cases are described. The first data developed from the Registry describe the number of cases and incidence rates for 1979. There were 27,557 incident cancer cases identified in 1979. By specific primary site, the leading causes of cancer incidence among New Jersey males were cancers of the lung, prostate, colon, bladder, and rectum. Cancer of the breast was the most common type of cancer among New Jersey females. Cancers of the colon, cervix uteri, lung, and corpus uteri ranked second through fifth in relative frequency of occurrence. Comparison of New Jersey data with a national estimate from SEER data showed the total cancer rate for New Jersey males to be higher than that for males in all SEER areas, while the female rate in New Jersey was lower than SEER. Within major site groupings, the greatest difference in rates for males occurred for cancers of the urinary system. For females, the greatest difference between New Jersey and SEER rates for major site groupings was for

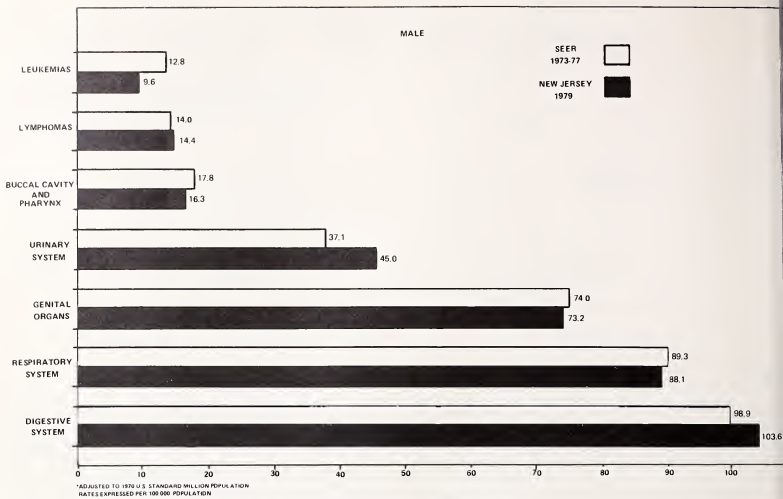


Figure 2—A comparison of the average annual age-adjusted incidence rates for males.

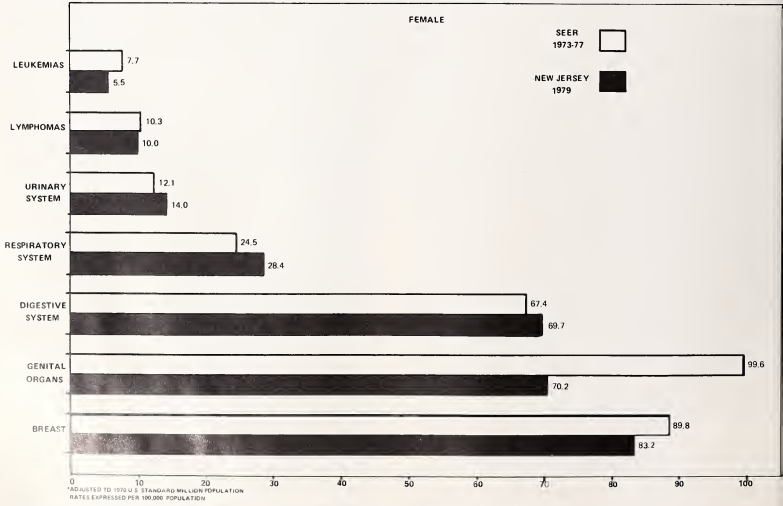
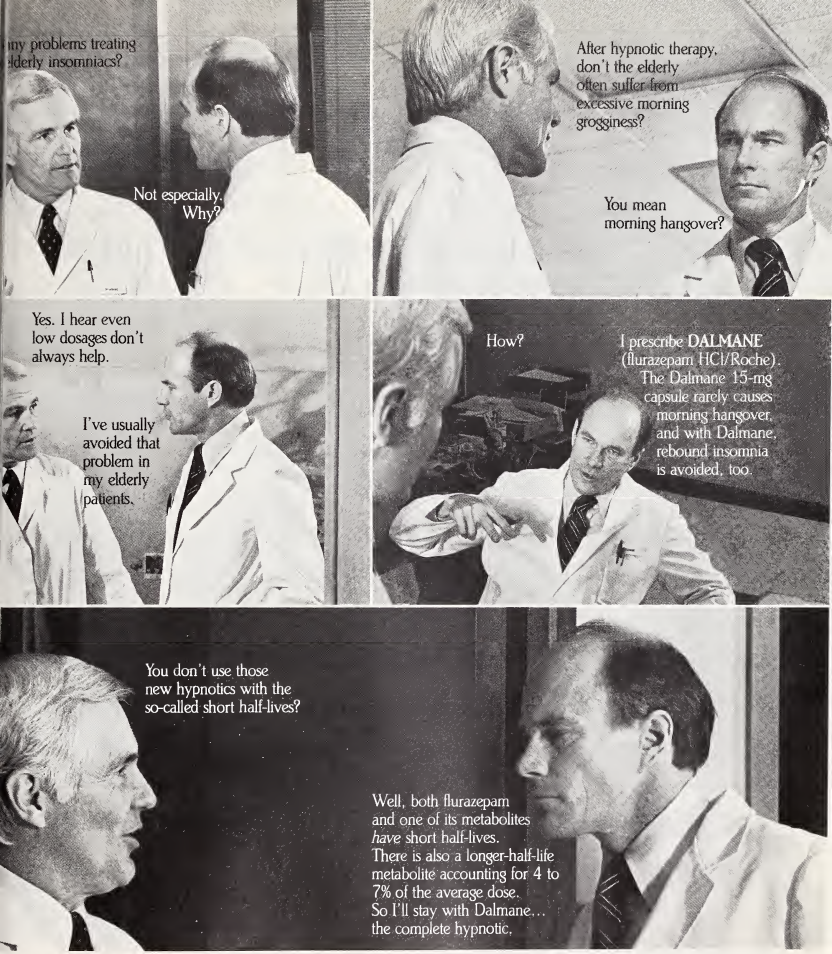


Figure 3—A comparison of the average annual age-adjusted incidence rates for females.

cancers of the female genital system. A deficiency in receiving reports of patients diagnosed outside of New Jersey is noted in the registry data and the methods by which the deficiencies may be corrected are addressed.

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Pulmonary Edema Complicating Epiglottitis

VICTOR N. BLANKSON, M.D., New Brunswick*

Epiglottitis is an acute obstructive infection of the upper airway of children. Treatment consists of the establishment of an adequate airway and the administration of antibiotics. A few of those affected develop pulmonary edema and deteriorate after intubation. The management of this complication is the application of positive end-expiratory pressure (PEEP).

Acute epiglottitis is an acute obstructive H. flu infection of the supraglottic structures that include the epiglottis, aryepiglottic folds, arytenoids, and ventricular bands. Epiglottitis develops with dramatic rapidity from fever, sore throat, dysphagia, and drooling, to upper airway obstruction. The management consists of the establishment of an airway for a few days and the administration of antibiotics. Instead of becoming better after the establishment of a patent airway, some patients become worse.

CASE REPORT

A six-year-old boy reported not feeling well the night before admission. He had no specific signs or symptoms and had an uneventful night. The next morning, he developed fever up to 106°F and complained of a sore throat; he refused to eat or drink. Subsequently, he developed respiratory difficulty with tachypnea and subcostal retractions. The patient was taken to his pediatrician who suspected epiglottitis but did not attempt forcibly to visualize the epiglottis. The patient was sent to Middlesex General Hospital, New Brunswick.

Examination disclosed an anxious-looking boy in a sitting position with his neck hyperextended; the respiratory rate was 40 to 50/minute and moderate retractions were noted. Pulse rate was 120/minute. The chest sounded clear. A lateral neck x-ray showed an enlarged epiglottis consistent with epiglottitis (Figure 1). An otolaryngologist and anesthesiologist transferred the patient to the operating room and inserted an oral airway easily, but when bleeding prevented the placement of a nasotracheal tube, they performed a tracheostomy (Figure 2). In the recovery room, the patient's lips appeared cyanotic. Blood gas analyses were (on room air): pH = 7.21, pCO_2 = 40, pO_2 = 42. Oxygen at 40 percent was added but oxygenation did not improve. The patient was attached to a mechanical ventilator while breathing spontaneously and positive end-expiratory pressure (PEEP) was applied to a maximum of 7 cm H_20. The patient was given enough fluid to maintain a urine specific gravity between 1.020 and 1.030. His $Pa0_2$ improved dramatically so that by the next morning the PEEP was discontinued while on an $FI0_2$ of 30 percent. Later the oxygen also was discontinued. The tracheostomy was removed after four days. The patient spent one week in the hospital.

DISCUSSION

In 1977, Travis et al. described a patient with epiglottitis and another with croup who had such a course.[1] In 1980, Galvis et al. estimated that 5 percent of their patients with epiglottitis over a ten-year period at the Children's Hospital, Pittsburgh, had this complication.[2,3] Another additional case was reported by Hurley and Kearns.[4] Recently, Costigan et al. published an article on the respiratory status of children with epiglottitis.[5]

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Figure 1—Lateral neck x-ray showing swelling of the epiglottis and adjacent structures consistent with acute epiglottitis.

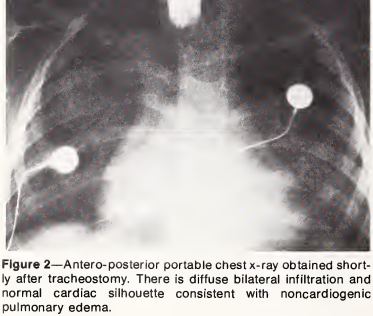


Figure 2—Antero-posterior portable chest x-ray obtained shortly after tracheostomy. There is diffuse bilateral infiltration and normal cardiac silhouette consistent with noncardiogenic pulmonary edema.

PULMONARY EDEMA

Pulmonary edema is the accumulation of excess extravascular lung fluid which is the exaggeration of a normal phenomenon. The balance of forces at the capillary locus favors the exudation of fluid into the interstitium. This fluid is evacuated by the lung lymphatic system situated at the perivascular and peribronchial area.[7] It is known that lymphatic flow increases manyfold in response to increased tissue fluid and it is only when the lymphatic system is exhausted that fluid accumulates. For this reason, pulmonary edema fluid is first interstitial before it becomes alveolar in location. At the interstitial stage of pulmonary edema the chest x-ray is not revealing, but blood gas studies will show an increased arterial-alveolar gradient with a low pCO_2 initially.

Pulmonary edema may be divided into two categories with different pathophysiology.[6,7] Cardiogenic pulmonary edema (CPE) is characterized by an increased capillary pressure and is due to cardiac failure of diverse causes. Noncardiogenic pulmonary edema (NCPE) is due to an alteration in lung capillary permeability. The pharmacologic management of cardiogenic pulmonary edema reduces pulmonary capillary pressure and increases cardiac output. The management of noncardiogenic pulmonary edema is essentially nonpharmacologic, the most salient aspect of which is the application of positive end-expiratory pressure, either with mechanical ventilation or with spontaneous breathing.[8]

MECHANISM OF PULMONARY EDEMA ASSOCIATED WITH UPPER AIRWAY OBSTRUCTION

In the first report by Travis et al., one of the patients underwent pulmonary artery catheterization, which revealed low pulmonary capillary wedge pressure (PCWP).[1] This indicated that the probable cause was an alteration in pulmonary capillary permeability. The pathophysiology was not evident but different mechanisms were cited. Drinker's experiment with dogs showed that dogs with inspiratory obstruction and hypoxia developed pulmonary edema but they did not develop pulmonary edema with hyperoxia and inspiratory obstruction. Studies on humans at high altitudes showed that hypoxia causes pulmonary arteriolar vasoconstriction. In addition, severe hypoxia and anxiety can cause a massive sympathetic discharge, resulting in a systemic vasoconstriction and a shift of blood to the pulmonary circulation. Inspiration through an obstructed upper airway also may increase the effects of the negative transpulmonary pressure. Transmission of this pressure to the peribronchial interstitial space pulls fluids normally formed at the alveolar capillary level to a point where the pulmonary lymphatic system is overwhelmed. Travis et al. also suggested that there may be a reduction in left ventricular function. Galvis et al. accepted the above explanation but went on further to suggest that the release of the intrathoracic pressure by intubation results in the pulmonary edema.[2] This seems highly unlikely because pulmonary edema cannot form this rapidly. Secondly, in the few patients in whom arterial blood gases were obtained before the intubation, there was always a large arterial-alveolar oxygen gradient ($AaD0_2$). Few of these patients had chest x-rays before intubation. Some patients with this complication still may have normal appearing chest x-rays in the presence of developing pulmonary edema. Acute pulmonary edema at the interstitial stage may show normal auscultation and normal chest x-rays.

MANAGEMENT

Treatment of pulmonary edema with upper airway obstruction is purely mechanical and consists of the application of positive end-expiratory pressure either with spontaneous breathing or with mechanical ventilation. These patients may be mildly or moderately dehydrated because of fever and tachypnea with the mouth open, which increases insensible water loss. This loss, as well as the refusal to drink because of dysphagia, may occur for several hours before the patient is seen by a physician. We watch the urine specific gravity closely. If both this and the urine production are abnormal, we administer crystalloid solutions intravenously but occasionally intravenous colloid solutions are required in the management of noncardiogenic pulmonary edema. We do not give diuretics.

Excessive positive end-expiratory pressure (PEEP) is not necessarily good. Each patient, as shown by Suter et al. has his optimal PEEP, beyond which compliance decreases

ınd the PaO_2 drops again.[8] We increase the PEEP by only cm H_2O at a time. This may be slow but it assures that we lo not miss the optimal PEEP.

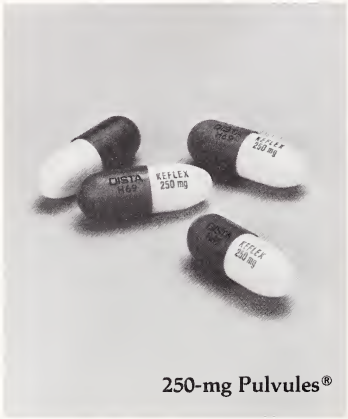
CONCLUSION

Noncardiogenic pulmonary edema complicates the course of epiglottitis in a small percentage of children. The diagnosis should be recognized easily by obtaining blood gas studies as soon as the airway is secured. Sampling of the arterial blood should not depend on the patient's color, which has been shown to be a poor indicator of PaO_2. The management is the application of positive end-expiratory pressure and enough intravenous to prevent hypovolemia in these mildly to moderately dehydrated patients.

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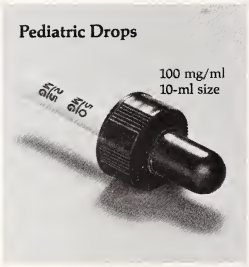


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Acute Pleural Effusion Induced by Ampicillin

MELVIN HERSHKOWITZ, M.D., Jersey City*

A previously healthy 40-year-old woman developed an acute pleural effusion after ingesting a 500 mg capsule of ampicillin. No other etiologic factor was discovered for the effusion, which resolved in 72 hours. This appears to be the first described episode of such an immunoallergic response to ampicillin. Other drug-induced pleural effusions briefly are reviewed.

The development of slowly evolving pleural effusions, as reactions to ingestion or parenteral administration of a number of drugs, is a well-known phenomenon. Acute drug-induced pleural effusions, however, have been reported to date only with nitrofurantoin.[1] Drug-induced pleural effusions usually disappear without specific treatment, and leave no serious long-term sequelae.

This report describes the unusual circumstances of an acute evanescent pleural effusion caused by the oral ingestion of one capsule of ampicillin.

CASE REPORT

A 40-year-old black woman was brought to the emergency room of the Jersey City Medical Center by ambulance on May 25, 1979. Four years prior to this admission, she had taken oral penicillin for a sore throat, and developed immediate hypotension and urticaria. Apparently forgetful, uninstructed, ignorant, or heedless of the past, she took a 500 mg capsule of ampicillin for another sore throat on this day of admission. Within 30 minutes, she developed severe generalized itching and shortness of breath. On arrival at the emergency room, her blood pressure and pulse were unobtainable. Respirations were 26/minute. After treatment, the blood pressure rose to 110/60, and the pulse rate was 112/minute, sinus tachycardia, with normal first and second heart sounds. There were no murmurs, clicks, or rubs. The head, eyes, ears, nose, and throat were normal. There was no lymphadenopathy, rash, or jaundice. The breath sounds were normal all over the lung fields; there were no rales, wheezes, or friction rubs. The abdomen was soft; there was no tenderness or palpable masses. The liver and spleen were not enlarged. The bowel sounds were normal. The neurological examination was normal.

A chest x-ray on admission showed a normal heart, clear lungs, and no abnormalities of the diaphragms or thoracic bony cage.

Extensive laboratory data on admission included a normal urinalysis, and showed only the following few deviations from the normal range: white blood cell count: 22,000 mm^3; differential white cell count: 96 percent polynuclears, 4 percent lymphocytes; blood glucose: 265 mg/dl; and SGOT: 54 units.

HOSPITAL COURSE

On day one the patient was treated in the intensive care unit with epinephrine, levoartenol bitartrate, dexamethasone, and diphenhydramine. She responded well. Her blood pressure rose and stabilized at 120/80. Because of her prompt response to subcutaneous and intravenous treatment, it was not considered necessary to insert a CVP line,

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and this procedure was not attempted. Her itching ceased. A repeat chest x-ray examination, eight hours after admission, showed a left pleural effusion, estimated at 600 ml (Figure 1). Thoracentesis showed clear pleural fluid. The specific gravity was 1.017, the protein content 140 mg/dl, and the lactic dehydrogenase 100 units. There were 75 red blood cells mm^3, and no white blood cells. A culture yielded no growth of pathogenic organisms. Cytologic study showed no abnormal or malignant cells. Complement measurements in the pleural fluid were not done.

The patient was asymptomatic on day two. Vital signs were normal. There was dullness to percussion, and decreased intensity of the breath sounds over the left lung base. The remainder of the physical examination was normal. A repeat chest x-ray examination showed persistence of the left pleural effusion. The patient was transferred to a general care floor.

On day five repeat chest x-ray examination showed a normal heart and clear lung fields (Figure 2). The previously noted left pleural effusion had resolved completely within 72 hours. The percussion note and breath sounds over the left lung were now normal. The patient was observed without further therapy until the tenth hospital day, at which time a repeat chest x-ray examination was normal prior to discharge.

Additional laboratory studies included negative tests for antinuclear antibody (ANA) and hepatitis B surface antigen. The complement fixation and cold agglutinin tests for mycoplasma were negative. A tuberculin test was negative in 48 and 72 hours.

DISCUSSION

An allergic reaction to oral ingestion of a 500 mg capsule of ampicillin was the probable cause of this patient's acute pleural effusion. The benign course, the transudative nature of the effusion, the subsidence of the effusion within 72 hours, and the absence of serious clinical or laboratory abnormalities outside the pleural space, all suggested that systemic involvement with a collagen disease or a specific infection were improbable. The setting was not that of an occult pulmonary embolism with pleural effusion, a diagnosis to be considered in some otherwise unexplained effusions.

Rapidly evolving, evanescent, drug-induced pleural effusions previously have been reported only with nitrofurantoin. Chronic effusions may occur as responses to many drugs, particularly busulphan, hydralazine, nitrofurantoin, procainamide, and, rarely, penicillin. When penicillin is the offending drug, the clinical spectrum may be that of the well-recognized, drug-induced systemic lupus erythematosus (SLE)-mimetic syndrome, with a positive ANA test. The drug-induced SLE-mimetic syndrome has been known for at least 20 years. Ladd reported one of the first cases in 1962, with procainamide as the offending agent in a patient who had a pleural effusion which lasted for six weeks.[2] When hydralazine induces pleural effusions in the SLE-mimetic syndrome, there is a relationship to duration of therapy. Patients taking hydralazine develop pleural effusions only after six months of therapy, and the effusions tend to be chronic and slow to subside.[3]

One of the best discussions of drug-induced hypersensitivity reactions in the lung is that by Rosenow, who succinctly comments that diagnostic methods remain inconclusive, and that the history itself "is the most common, and, unfortunately, usually the only method of implicating a hypersensitivity reaction as the cause of the patient's problem."[4] Rosenow lists 27 drugs, including ampicillin, that are capable of causing the SLE-mimetic syndrome, but he does not describe pleural effusions in these cases or in any other types of drug-induced pulmonary reactions.

Criep's book on allergic and immunologic diseases contains comments on adverse drug reactions and hypersensitivity diseases of the lung, but there is no mention of pleural effusions in either category.[5]

Fishman's standard reference on pulmonary disorders gives a comprehensive survey of pleural diseases, including specific descriptions of hypersensitivity reactions in the pleura to drugs. Pleural effusions are described following use of methysergide, nitrofurantoin, and practolol, but there is no mention of ampicillin. Mechanisms and pathogenesis are not elucidated.[6]

A recent authoritative reference work on immunoallergic diseases contains discussions of anaphylaxis, urticaria, angioedema, and adverse drug reactions.[7] Ampicillin is mentioned as prominent among drugs that may cause anaphylactic reactions in the lung, but the anatomic response

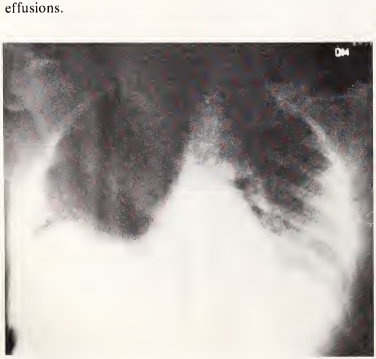


Figure 1—Antero-posterior chest x-ray, taken eight hours after admission, showing left pleural effusion.

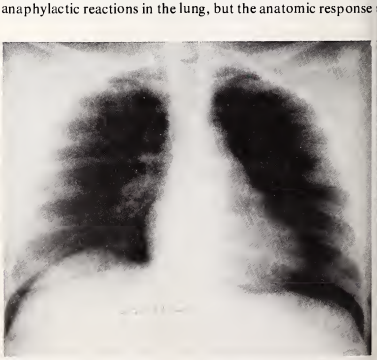


Figure 2—Postero-anterior chest x-ray, taken on the fifth hospital day, showing subsidence of the left pleural effusion.

s described as pulmonary edema rather than pleural effusion. The commentary on adverse drug reactions states hat nitrofurantoin is "unique in producing pleurisy with effusion."[7] We now may add ampicillin to this "unique" category, in view of the events described in this report.

It is of interest that there is no apparent relationship between ampicillin's great propensity to cause cutaneous eruptions and its role in producing the SLE-mimetic syndrome with concomitant pulmonary abnormalities.[8,9] Previously healthy patients, patients with infectious mononucleosis, and patients with hyperuricemia who take allopurinol, all may have a high incidence of ampicillin rashes. None of the subgroups, however, demonstrate an increased frequency of the SLE-mimetic syndrome with their ampicillin rashes.

The pleural components of drug-induced allergic and anaphylactic reactions are not much discussed in the literature on pulmonary and immunoallergic disease. There is a paucity of information on this subject. A 1981 review of the state of the art in *Current Pulmonology* contains no references to pleural effusions as part of the spectrum of hypersensitivity lung disease.[10]

Small and his group recently studied the immunologic abnormalities in the pleural effusions of 59 patients. They found very few abnormal tests for antinuclear antibody, anti-DNA antibody, or rheumatoid factor, and only a few alternations in complement levels in the pleural fluids of this heterogenous group of patients. There were no consistent patterns of abnormality in the pleural effusions which could be related to the specific diagnoses of genuine SLE, SLE-mimetic syndrome with procainamide, carcinoma, congestive heart failure, infections, or pulmonary embolism.[11]

The most recent published review of allergic reactions to drugs and biologic agents in 1982 gives a brief summary of pulmonary hypersensitivity reactions, with no mention of pleural effusion as an immunoallergic response in such circumstances.[12] Recent evidence supports the hypothesis that immediate immunoallergic responses to pencillin are IgE mediated, whereas the abnormalities that develop more gradually in the SLE-mimetic syndrome are associated with the presence of immune complexes. The former mechanism appears applicable to the patient described in this report.

CONCLUSION

A 40-year-old woman who had a previous urticarial and hypotensive allergic reaction to penicillin took one capsule of ampicillin immediately prior to the onset of an acute pleural effusion. She demonstrated no other definite etiologic factor for the effusion, which resolved spontaneously in 72 hours. It is probable that this extraordinary episode was caused by an immunoallergic response to ampicillin in her pleural space. This appears to be the first reported description of such a clinical event related to this widely prescribed drug.

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Adenosine Receptors*

BRUCE McL. BRECKENRIDGE, M.D., Ph.D., Piscataway**

Adenosine released from heart, brain, and other tissues functions as a local hormone or neuromodulator by interacting with specific receptors on cell surfaces. Two types of adenosine receptors (A_1 and A_2) have been found to be coupled to the enzyme which synthesizes cyclic AMP. Adenosine binding to A_2 receptors results in activation of the enzyme and to A_1 receptors in inhibition. Theophylline blocks both A_1 and A_2 receptor types, but recently synthesized analogs exhibit much higher potency and selectivity. Concepts emerging from such research may guide the development of new therapeutic agents.

Currently, rapid progress is being made in identifying cellular receptors for adenosine, and in exploring the functions which they regulate. Concepts emerging from these studies promise to guide the development of new therapeutic agents affecting the brain, heart, lungs, and immune system. In many ways, our understanding of adenosine receptors now is analogous to our concepts concerning adrenergic receptors in 1948 (α and ß types first characterized) or to our insights into histamine receptors in 1972 (H_1 and H_2 types identified). Only recently has it been established that tissues release adenosine in minute amounts, which then interacts with at least two types of receptors (A_1 and A_2) located on the surface membranes of nearby cells.

The impetus for the research which has led to the discovery of these two types of adenosine receptors can be traced to an observation in 1969 by Rall et al., then at Case-Western Reserve University School of Medicine. In experiments designed to gain understanding of cyclic AMP functions, they had added theophylline to preparations of guinea pig brain, expecting to enhance the amount of cyclic AMP accumulated in the tissue because theophylline had been shown in test tube experiments to block the inactivation of cyclic AMP. In this case, however, theophylline dramatically lowered the amount of cyclic AMP. A search for the basis of this puzzling effect revealed that theophylline inhibited the action of adenosine, which had been released from the tissue itself, and which appeared to act as a local hormone on specific cell surface receptors for adenosine causing cyclic AMP to increase.[10] The plausibility of such a concept was advanced by realization that three long-established, but largely independent, channels of information supported it. Elements of in-

*This article, the first in a series, is intended to be a brief review of recent advances in pharmacology and related preclinical sciences which will have utility in understanding the actions of both new and established therapeutic agents. The reviews are not designed to consider indications for specific drugs, incompatibilities, or dosage forms. Authoritative information on these topics is available in standard sources such as the *AMA Drug Evaluations*, 5th edition, 1983.

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formation about these three topics (adenosine, methylxanthines, and cyclic AMP) will be recounted briefly before describing the current concept of adenosine receptors.

Adenosine is a relatively small molecule containing a purine and ribose. In its phosphorylated form it is an integral part of numerous vital intracellular compounds such as ATP, the major high energy reservoir of cells, and of enzyme cofactors as well as of ribonucleic acids. Infusion of exogenous adenosine into the vasculature has been known for decades to have a vasodepressor action and particularly to be a potent vasodilator of coronary arteries.[1,7] The concentrations of adenosine in body fluids, however, are so low ($0.1\text{-}2.5 \times 10^{-6}$ M) that it has not been feasible to measure them until recently. A functional role for extracellular adenosine, therefore, was a matter of conjecture. It now is clear, however, that anoxia of the heart rapidly produces a large relative increase in adenosine release. The brain also elaborates adenosine within seconds of the onset of anoxia; in each case the increase occurs without appreciable loss of ATP from the cells and well before irreversible cytopathologic changes occur.[1] The molecular mechanism of adenosine release is obscure, but in the case of the heart, the source is cardiac cells and not nerve terminals.

Coffee, tea, and cocoa have been known to be stimulants since antiquity and, for the past century, this could be attributed to their content of the methylxanthines, caffeine, theophylline, and theobromine. Caffeine clearly is capable of increasing alertness, stimulating respiration, and cardiac action. Both caffeine and theophylline, which is so useful for its bronchodilator actions in the treatment of asthma, can cause cardiac arrhythmias and convulsions. Patterns of action of methylxanthines on the vasculature are complex, causing relaxation of most peripheral arterioles but producing constriction of cerebral vessels. Methylxanthine action at the cellular level has been attributed to inhibition of cyclic AMP hydrolysis; cyclic AMP-mediated events then would be potentiated in time and intensity. Doubt existed, however, about the adequacy of this explanation in the clinical setting because the concentrations of theophylline needed to inhibit cyclic AMP hydrolysis in the test tube were greatly in excess of those which could then be attained inside cells.

Cyclic AMP (adenosine 3':5'-monophosphate) was discovered by Rall and Sutherland in 1958 as a second messenger for glucagon acting on the surface of liver cells. The compound was synthesized from intracellular ATP when glucagon (or epinephrine) was bound to a specific receptor resulting in activation of a membrane-bound enzyme, adenylate cyclase. Cyclic AMP has been shown to trigger a cascade of intracellular reactions resulting in the phosphorylation of particular proteins. The phosphorylation of these specific proteins alters their properties as enzymes, ion gates, and contractile units. Virtually all peptide hormones (except insulin) and biogenic amines now are believed to act in this way.

Although no adenosine receptors yet have been isolated in pure form, they can be visualized reliably as highly specific macromolecules embedded in the plasma surface membrane of cells and coupled to adenylate cyclase. Their characterization has relied upon two types of experiments which have been made possible by the synthesis of new compounds chemically related to adenosine and to methylxanthines[8]: (1) Cell membranes containing receptors in association with adenylate cyclase are prepared and exposed to defined concentrations of the analogs of adenosine and methylxanthines. The activity of adenylate cyclase (measured as cyclic AMP formed) is variously found to be stimulated or inhibited. (2) Binding to cell membranes of radioactively labeled analogs of adenosine and methylxanthines is measured and the capacity of other nonlabeled analogs to displace the labeled compound is assessed. Typically, very low concentrations of such compounds are observed to saturate the binding sites and to stimulate or inhibit adenylate cyclase. The results of these two types of experiments are generally in close agreement, and they imply the existence of at least two types of adenosine receptors.

A_1 receptors predominate in adipose tissue and they mediate inhibition of adenylate cyclase when stimulated by adenosine or adenosine-like compounds in the nanomolar (10^{-9} M) range. The endogenous concentrations of adenosine are extremely low, as noted above, but in the case of adipose tissue the level is sufficient to provide tonic inhibition of adenylate cyclase. Most methylxanthines block this effect and consequently result in lipolysis.

"The impetus for the research which has led to the discovery of two types of adenosine receptors can be traced to an observation by Rall et al."

A_2 receptors mediate stimulation of adenylate cyclase by adenosine. They are the characteristic receptor type in liver. Substantially higher concentrations (10^{-7}-10^{-6} M) of adenosine-like agonists are required to affect A_2 receptors as compared to A_1 receptors. Many cell types, of which blood platelets are an example, contain both A_1 and A_2 receptors and exhibit a biphasic response to adenosine agonists. The principal physiological response of platelets to adenosine is one of inhibition to aggregation, and this effect is associated with increased cyclic AMP mediated by an A_2 receptor.[11] Brain tissue also contains both A_1 and A_2 adenosine receptors.[5] The predominant functional effect of adenosine, however, is to inhibit neuronal activity by inhibiting the release of neurotransmitters. Analogs of adenosine have been found in experimental animals to have sedative and anti-convulsant actions[4] and to modulate the dopaminergic control of movement.[6] The well-known excitatory actions of methylxanthines currently are attributed to blocking these actions of endogenous adenosine.

The complex patterns of signaling between cells of the immune system also may be regulated by endogenous adenosine. For example, adenosine promotes the conversion of T_R (helper) lymphocytes to T_S (suppressor) cells[2] and potentiates the release of histamine and leukotrienes from mast cells.[12]

The realization that adenosine is released from tissue and that adenosine receptors mediate a large number of important physiological functions has motivated an intensive search for new compounds exhibiting high selectivity either as adenosine agonists or antagonists. For example, a recently synthesized derivative of theophylline (1,3-dipropyl-8-(2-amino-4-chlorophenyl) xanthine) is 70,000 times more potent than theophylline in blocking adenosine A_1 receptors of brain.[3] Although the mechanism of action is obscure, a different theophylline analog, 3-propylxanthine, appears to be about four times more potent than theophylline in relaxing bronchiolar muscle, but to be virtually devoid of renal and central nervous system effects at doses affecting the lung.[9]

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COMMENTARY

Message from the American Medical Association

JOSEPH F. BOYLE, M.D.*

It is indeed a pleasure to come home. Although I may have found the sunny clime of southern California preferable to the winter and summer doldrums of the middle Atlantic states and Jersey City, nonetheless, my heart and my roots are here. That perhaps is why I am known to be somewhat blunt and outspoken on occasion. As a matter of fact, I have the reputation that if you do not want the answer, do not ask the question in the first place.

I also have had the opportunity, during the past three years, to serve with one of New Jersey's other representatives to the AMA, Jim Todd. There is no question about the fact that you indeed have done the physicians and the people of this country a tremendous service by sending Jim Todd to us. You've known it all along; now we know it—he is a real class act and good friend.

You also should know your delegation to the AMA generally serves you extremely well. Having been Speaker of the House in California for 11 years, I am pleased to be here at the time of Dr. Karl Franzoni's debut as Speaker. At the same time, I was looking forward to watching Henry Mineur, M.D., in action, having watched him assist speakers in the House of Delegates in the AMA for quite a few years. One other New Jersey representative to the AMA, of whom you should take special note, is Palma Formica, M.D., who now is serving us very ably as chairman of our Ad Hoc Committee on Women in Medicine; we are grateful to you for Palma.

Your speaker has asked me to bring you some message from the AMA. After two decades of an explosive expansion of resources poured into research, hospital construction, medical education, and the provision of hospital, health, and medical services, the American public has come to expect the best of us. I am not about to apologize for that because it is my judgment that physicians in this country are dedicated to provide the best that is humanly achievable. At the same time, national policies largely beyond our control now have brought us to a stage in which hospitals and hospital medical staffs have seemed bent on a course of collision and possible mutual destruction. A burgeoning supply of physicians has caused doctors to begin eyeing one another as potential poachers rather than fraternal colleagues. Medical schools are seeking new turf at the expense of neighboring privately practicing physicians who up until now have supported medical education voluntarily. Medical students, present or aspirant, dismay at ever achieving graduation or completion of postgraduate training without mortgaging their souls to the company store. A coalition of profligate politicians, employers, unions, and insurance companies have embarked upon a process called "changing the incentives" somehow to avoid paying the bill. The litany is endless. This is a moment in which leadership is of paramount importance.

I will very briefly touch upon some aspects of how the AMA has been striving to position itself to provide leadership.

Beginning in 1974, our organization literally was bankrupt; we had approximately $14 million in assets and were borrowing $1 million a month just to meet payroll. Just this last year, we produced programs with revenue resources in excess of $94 million; we have $129 million in total assets, major property holdings in Chicago and Washington, with an equity of $83 million in our Association. Publications which were losing more than $200 thousand a year in 1975, generate $20 million in advertising revenue today. With the specialty society journals and *JAMA* now being published in seven foreign editions and the *AMA News*, our 34 million periodicals published each year, make us the largest publisher of scientific and medical literature in the entire world. Since 1979, we have made 21 basic changes in the federation function and structure that allow our Association to operate in a truly democratic fashion, but with a speed, efficiency, economy, and direction better suited to times which demand both rapid and considered action.

We have reorganized the entire structure of the Association so that we can serve in a fashion that physicians in this country expect; namely, to provide representation in whatever form is expected of us. At the same time, we are on the cutting edge of the dissemination of scientific information, and a forum of a strong national body capable of setting and maintaining professional standards. Through our Council on Scientific Affairs, we have developed the capacity to displace the federal office of technology assessment and

*Dr. Boyle is President-Elect, AMA Board of Trustees. He presented this statement at MSNJ's Annual Meeting, April 30, 1983, in Atlantic City.

substitute our own diagnostic and therapeutic technology assessment program which allows us to evaluate new technologies as to their clinical utility and cost-effectiveness. We have displaced the FDA's patient practice inserts with our own patient medication information system. At the same time, we have developed a new national program to disseminate scientific information through an electronic network in cooperation with GTE, so that there now is available to physicians in their own offices, instant access to the latest in drug prescribing information, diagnostic characteristics of over 3,000 disease categories, and instant access to scientific literature. We have developed a new socioeconomic monitoring system which allows us, on an instantaneous basis, to monitor what is occurring in medical practices all over the United States. At the same time, we have provided for true representation in our House of Delegates, our policymaking body, virtually all of the recognized medical specialty societies, medical residents, and students, and have created a section for medical schools. At the present time, we are developing a similar section for direct representation for hospital medical staffs in our House of Delegates.

After the setbacks that we experienced in the 1960s and 1970s, we have revitalized our legislative efforts so that during this past year we were recognized as a true political force in the United States. While we were doing battle with the FTC, we occupied not only the attention of the FTC and the administration, but both houses of Congress as well. We attracted their attention sufficiently so that we have had an opportunity during this past four months to meet with the chairman and other representatives of the FTC and have reached agreement on changes which now they realize need to be made. They recognize the essential part that local societies play in peer review both as to the competence of physicians, the standards by which they may practice, and the fees that they should charge. We indeed have created a strong association capable of producing leadership and, because of that posture of leadership, we now are embarking upon the most ambitious program ever undertaken by any association, public or private. That is to create a health policy agenda for the American people. I will not attempt to go into the details of that program with you because it would require too much time, however, I will share with you a few observations as to its genesis and its current progress. That we have the finest medical care system in the world today is unchallenged; yet, without citing how much it is worth in terms of lives saved, lives restored, or the quality of life enhanced, the 10 percent of GNP pricetag that goes with it faces serious challenge. Over the past two decades, federally funded national planners, largely excluding medical and other experts in the field, have fussed, fumed, and repeatedly failed logically to prioritize the allocation of resources for medical education or for basic or applied research, to adapt to new technologies or to the interaction of public and private interests. They did not evaluate the impact of emerging systems for the payment of or the delivery of services; nor did they plan for anything other than for restricting access, rationing care, and/or contracting the resources. At the same time, we have had multiple competing programs jousting with one another for larger and larger shares of diminishing dollars. In short, we have no agenda, rational or otherwise, for a future health policy for the American people. Because of this void and because the AMA has the recognized capacity to lead, 150 different institutions and organizations, including the medical specialty societies, medical schools, research institutions, hospitals, business organizations, state and federal government, state medical societies, and a number of public members have accepted our invitation to participate in this truly prestigious and enormously important task. No organization, public or private, has ever before embarked on a project of this magnitude. We expect to succeed but not by attempting to build some new system or attempting to compromise between conflicting communities of interest, and certainly not by asking demographers, economists, or social scientists to help us write a global national health plan or a road map to medical-social munificence. Rather, we intend to succeed by identifying those basic principles upon which our entire system rests and the infra structure which has grown up with it that leads us to its current position of unparalleled preeminence in the world. After having reached consensus upon those basic principles, we will then turn our attention to policies based upon them which should provide a lasting and effective agenda, for providing medical and health care for the people in the United States for today, tomorrow, and decades to come.

We intend to succeed because we do have the leadership. Is the leadership in New Jersey committed to provide the kind of direction that your colleagues need? From what I know of your representatives in the AMA House of Delegates, I believe you are. Leadership comes in many shapes and forms and from many sources, but the ultimate leadership involves a few basic elements: constancy, concern, innovation, and courage.

Constancy. Consistent overtime building of confidence in good times and bad, persistent adherence to fundamental sound principles. Yes, an anchor in the flood tide, a beacon of dark light, and a voice and force that can be depended upon.

Concern. Learn to listen to and learn from our members.

Innovation. Exploring new and better ways; imagination buttressed by careful research and market analysis. Stretch the limits of the probable; explore the outer reaches of the possible; challenge the frontiers of impossible dreams because today's fantasy may well become tomorrow's reality.

Courage. The buck stops somewhere. When truly difficult decisions need be made, when the options either are to stand for principle or to accommodate; speak out when a strong voice is needed though silence might serve you better. Be on your feet when sitting would be easier and more comfortable. Be in front when the pack is either for you or after your hide. In honorable defeat or glorious victory be a pillar to which others may look for strength, adherence to conscience and determination.

We are a free and independent profession in this country; will we remain so? I submit to you that freedom is not free and leadership extracts its price as well. For in these days there is a need for a commitment to leadership. My question then, will you be that leadership? Constancy, concern, innovation, and courage. Leaders who have the commitment see to it that our colleagues, who are straining in their search for direction, realize that a commitment to maintain our profession free and independent is in our hands. Together we can change the environment, we can create an agenda for action.

Support Groups

DAVID I. CANAVAN, M.D., Lawrenceville*

The adage, "Nothing succeeds like success," is an appropriate way to begin a discussion of the role of the support group in the life and rehabilitation of our recovering physicians.

In Akron, Ohio, in June 1935, a talk between a New York stockbroker and an Akron physician was the original spark which ignited a conflagration that was to burst across the country and the world consuming the despair of countless victims of the disease of alcoholism and providing an awesome light to lead them back to a new and better life of sobriety.

Bill W., at the depths of despair in the downhill spiral of his own alcoholism, was confronted by a friend, a former drinking partner, who had found release from his own distress in a return to religion. The friend found a spiritual bulwark to sustain the crumbling foundation of his own career, his health, and his life. To Bill W. he seemed a living miracle, a testimony to the impact of spiritual rebirth on the life of a dying spirit. Bill W. had his own personal prejudices about God and religion, but he was able to accept the concept of "a power greater than myself." He became convinced that "belief in that higher power, plus enough willingness, honesty, and humility to establish and maintain the new order of things, were the essential requirements."

Bill W. found a great sense of inner peace with this decision and learned very quickly that "faith without works is dead." It was only in carrying the message he had received to his suffering fellow alcoholics that his own faith could survive and flourish. And so, the program began. In 1983, this fellowship of "recovering drunks" has grown to almost 48,000 groups in 110 countries. Interestingly, about one-third of the members are women and almost 15 percent are under age 30. In just under 50 years, the long-term prognosis of this devastating disease has seen a major turnaround.

I have developed a set of reasons from my own years of experience as to why the program works. It works in many ways. Alcoholics Anonymous (A.A.) provides:

1. **A Place to Go.** For the active alcoholic, especially the alcoholic who has been drinking in bars and taverns, when drinking activities cease, there occurs a large void in life. Attending A.A. meetings provides an important way to fill part of this void.

2. **Companionship.** The fledgling member of the program finds in the group the opportunity to develop new social contacts and new friendships to sustain him at this vulnerable point in life. He finds "fellow sufferers" who know and understand from personal experience exactly what he is going through.

3. **Inspiration.** "No matter how bad things are, they always could be worse." When the new member begins to listen to the experiences of new friends in the program, he learns that so many others have been far worse than himself and yet they have been able to rebuild a meaningful, sober life. This direct personal contact with their recovery is an invaluable source of encouragement.

4. **Moral Support.** The fellowship of A.A. is exactly that—an organization devoted to mutual aid and assistance. The new member finds a group of concerned human beings, who share the same challenges and who have bonded together to help one another fight the daily battle against the disease that none of them wanted. He finds people who do understand, to whom he can turn at any hour of the day or night for help when he feels he is in trouble.

5. **Education.** If you wanted an intensive course in the nature, the natural history, the prognosis, and the treatment of alcoholism, you probably would be hard pressed to find a better course than "the school of hard knocks and experience" that is provided at every A.A. meeting. Here the new member learns in intimate detail of the nature of this insidious disease from those who know it best from their own long, intensive personal experience.

6. **Group Therapy.** Psychiatry discovered marked therapeutic benefit from the interchange of experience, ideas, symptoms, problems, and solutions between patients with common psychiatric diagnoses. In a sense, in a very informal way, the "closed" A.A. meeting provides this same therapeutic setting in which fellow sufferers of the disease that is alcoholism can share this same benefit.

7. **Self-Sacrifice.** There is no one more selfish and self-centered than the drinking alcoholic. Just as Bill W. realized that faith without works is dead, so the program he co-founded demands its disciples give of themselves to bring the message of recovery to others. When the recovering alcoholic sacrifices his own time, energy, and resources to assist his fellow alcoholic in grasping the message and the program, he has gone a long way in overcoming these attitudes.

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TABLE 1
The 12 Steps of A.A.

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

8. **Humility.** Pride (false pride, perhaps!) and arrogance are classic features of the personality of the drinking alcoholic. In its own insidious way the therapeutic environment of the support group deflates this false pride and arrogance and replaces it with an honest and realistic inventory of personal strength and weaknesses and a solid foundation of self-respect and appropriate humility that is not self-destructive.

9. **Spirituality.** For Bill W., this was the most important thing that this new way of life provided. For many of its members the spiritual elements of the program remain the key element in their own success. The belief in the existence of a "higher power" to whom they can turn in times of deep personal need provides the strength they need to cope with the pitfalls and challenges of their new alcohol-free life. For some, this involves a return to the formal religion and practices of their prior life. For others, it is a philosophical commitment to a poorly understood metaphysical force. There is no question in my own mind of the great need we all have for a spiritual orientation in our lives. I am convinced that, while not all will admit it, this probably is the greatest benefit this program of recovery provides.

While the foregoing is my own interpretation of how the program works, it would be inappropriate if I did not include the 12 steps to sobriety that the program itself outlines (Table 1).

As the program grew, and a wide diversity of members was accumulated, certain issues began to arise that the leaders felt were a source of distraction from the original goals and principles of the movement. As a result, they developed and promulgated a set of principles to guide the individual groups and their membership in maintaining their course along the one that was originally charted (Table 2).

Soon it became apparent that the philosophy and the steps of this program were not only applicable to other problems, but also when tried were very effective.

TABLE 2
The 12 Traditions of A.A.

1. Our common welfare should come first; personal recovery depends upon A.A. unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for A.A. membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups of A.A. as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. A.A. forever should remain nonprofessional, but our service centers may employ special workers.
9. A.A., as such never ought to be organized; but we may create service boards or committees directly responsible to those they serve.
10. A.A. has no opinion on outside issues: hence the A.A. name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we always need maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of our traditions, ever reminding us to place principles before personalities.

Because of the kindred nature of the disease of drug abuse, the program quickly spread to the population of "drug abusers" in the form of Narcotics Anonymous. Many of the workers in the field of substance abuse are convinced that alcoholism and other sedative abuse simply are different manifestations of the same disease and hence the conclusion that this program would benefit both groups is unavoidable.

Other illnesses in which the active stages of the illness are associated with an "inner compulsion" to behavior that is not in the best interest of the individual have found that the same principles could be employed with a positive therapeutic response. Gamblers Anonymous, Overeaters Anonymous, Smokers Anonymous, and Neurotics Anonymous are prime examples.

In the impaired physicians movement throughout this country, the role of the support group is considered an essential part of the therapeutic program for our recovering physicians. It is almost a "sine qua non."

We feel that the special needs and problems of the recovering "professional" warrants the involvement of our recovering physicians in a support group that is organized for "health professionals." However, this should not be the only support group in which these physicians are involved. The best "support" is at the grassroots level—down in the trenches with the troops. As a disease, alcoholism respects no level of social, educational, or professional success but rather brings its victims to the common ground of their shared disease.

The best sobriety is found when all airs are put aside and recovering substance abusers interact only on the level of their shared illness and desire for recovery.

WHAT IS YOUR OPINION?*

Surgeon's Role in Treatment of Breast Cancer

RALPH S. GRECO, M.D., New Brunswick**

The National Cancer Institute has estimated that in 1983 there will be 115,000 new cases of breast cancer diagnosed and 37,500 women will die of this disease.[1] In New Jersey, 4,700 new cases of breast cancer will be diagnosed and 1,600 women will die from breast cancer. Almost all of these women will have undergone radical or modified radical mastectomy.

Halsted's reports of the radical mastectomy span from 1891 to 1907.[2-4] His patients had an advanced form of breast cancer and 72 percent of them had axillary metastases at the time of operation. Sixty-seven percent succumbed within 2 years of operation. Alternatives to mastectomy have been proposed for more than 30 years. Many of these reports from European literature generally have supported the use of segmental mastectomy and breast irradiation in highly selected patients. Unfortunately, none of these studies was conducted as part of a prospective randomized trial and, therefore, their impact has been limited severely. One exception to this was the report in 1981 by Veronesi of the National Cancer Institute in Milan in which patients with stage 1 breast cancer prospectively were assigned the classic Halsted mastectomy or quadrantectomy and radiation therapy.[5] The two groups of patients were not significantly different in terms of axillary lymph node metastases, the development of local or distant recurrence, or survival. Unfortunately, the longest followup was 7½ years.

Discussion of the treatment of breast cancer tends to be emotional and focuses on minor differences in survival rates. Proponents of radical and modified radical mastectomy report survival rates of 80 or 90 percent for patients with stage 1 breast cancer. This tactic avoids an explanation of why 10 or 20 percent of these patients succumb after an operation which should be curative for virtually all of these patients. The development of local recurrence or distant metastases in women with early breast cancer forces us to conclude that in many patients the disease is systemic at the time of diagnosis. These micrometastases disseminate beyond the local-regional site early in the course of the disease before the primary lesion is clinically evident. As such, surgical therapy plays a role in the treatment of the local-regional manifestations of this disease and other methods must be sought to treat the systemic component.

There is little question that the breast cancer we treat today bears little similarity to the breast cancer treated by Halsted. Clearly, we are treating an earlier stage of this disease and local control well may be accomplished without mastectomy. The clinical and biological hypotheses which led Halsted to develop the radical mastectomy have been replaced by a more sophisticated understanding of the biology of the disease. This demands a reappraisal of surgical therapy. The main reason that survival rates are improving in breast cancer is that we are treating an earlier form of the disease. The fear of mastectomy probably is one of the main reasons for delaying medical treatment. Procedures less than mastectomy do not need to prove themselves superior to radical mastectomy, rather only that they are equal in their ability to control the disease locally.

It is premature to conclude that procedures less than mastectomy should replace the radical and modified radical mastectomy procedures. Studies such as those being conducted by the National Surgical Adjuvant Project for Breast and Bowel Cancer and the National Cancer Institute, if enough patients are entered into these protocols, will provide the answer during the 1980s. Any objective reviewer must conclude that undoubtedly there is a group of patients for whom segmental mastectomy with or without radiation therapy will become the treatment of choice during the next decade. Segmental mastectomy and axillary dissection are being used more often by surgeons throughout the country. To some degree, this is dictated by the patient and to some

*We encourage our readers to write opinions on topics of interest. Send your opinion to Editor, *The Journal*, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

**Dr. Greco is Chief, Section of General Surgery, UMDNJ-Rutgers Medical School. Correspondence may be addressed to Dr. Greco, UMDNJ-Rutgers Medical School, Academic Health Sciences Center, CN 19, New Brunswick, NJ 08903.

degree by the clinical judgment of the surgeon. We only can hope that surgeons not involved in randomized prospective trials will begin to do so, or the results of their efforts will have no impact on future generations of women who develop breast cancer. In addition, surgeons who choose to perform the more standard operations would be well advised to take a more dispassionate approach to the treatment of this disease in their daily interactions with their patients who, after all, must live and die with carcinoma of the breast. The protocols of the National Surgical Adjuvant Project for Breast and Bowel Cancer and the National Cancer Institute offer the hope that the answers to these questions will be available on the 100th anniversary of Halsted's description of the radical mastectomy in 1891.

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3. Halsted WS: The results of operations for the cure of cancer of the breast performed at Johns Hopkins Hospital from June 1889 to January 1894. *Ann Surg* 20:497, 1894.
4. Halsted WS: The results of radical operations for the cure of carcinoma of the breast. *Ann Surg* 46:1, 1907.
5. Veronesi V. Saccozzi R, Del Vecchio M, et al.: Comparing radical mastectomy with quadrantectomy, axillary dissection, and radiotherapy in patients with small cancers of the breast. *N Engl J Med* 305:6-11, 1981.

1983-1984 SPECIAL COMMITTEES & SPECIAL/LIAISON REPRESENTATIVES

Academy of Medicine of New Jersey
(1) Board of Trustees/Liaison Committee
(Liaison requested by AMNJ—June 19, 1966)

Alfred A. Alessi, M.D. ..... Hackensack
Arthur Bernstein, M.D., *Secretary* ..... South Orange
Sherman Garrison, M.D. ..... Bridgeton
(2) Postgraduate Medical Education Study Committee
(Representative requested by AMNJ—November 15, 1964)

Edwin W. Messey, M.D., *Chairman, Committee on Medical Education* ..... Willingboro
William Pomerantz, M.D., *Vice-Chairman, Committee on Medical Education* ..... Randolph Township

Agent Orange Commission, New Jersey
(Established by Governor—March 1980)

Laura E. Morrow, M.D. ..... Passaic

AMA-Education Research Foundation
(Liaison requested by AMA—October 7, 1951)

Palma E. Formica, M.D., *Chairman, Committee on Medical Student Loan Fund* ..... New Brunswick

Archivist Historian
(Appointment requested by Medical History Society of New Jersey—April 1982)

Morris H. Saffron, M.D. ..... New York

Audit Review Committee (1982-1983)
(Appointed annually to review previous year's audit)

Frank Y. Watson, M.D., *President-Elect, Chairman* ..... Glen Ridge
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Paul J. Hirsch, M.D., *Treasurer, Consultant* ..... Bridgewater
William Greifinger, M.D., *Chairman, Committee on Finance and Budget, Consultant* ..... Belleville
Frank Campo, M.D., *Vice-Chairman, Committee on Finance and Budget, Consultant* ..... Trenton

Blindness, New Jersey Society To Prevent
(Requested by Society for the Prevention of Blindness—March 19, 1978)

William Lesko, M.D., *Chairman, Committee on Conservation of Vision* ..... Clifton

Blood Bank Association, New Jersey
(Liaison requested by New Jersey Blood Bank Association—April 25, 1969)

Frank Campo, M.D. ..... Trenton

Blood Banking Task Force for New Jersey
(UMDNJ—October 1981)

Frank Campo, M.D. ..... Trenton

Blue Cross/Blue Shield Plans of New Jersey, Permanent Committee on
(Appointment of Committee requested by MSP—April 16, 1960)

Douglas M. Costabile, M.D., *Chairman, Board of Trustees* ..... Murray Hill
Alexander D. Kovacs, M.D., *President* ..... Scotch Plains
Vincent A. Maressa, *Executive Director* ..... Lawrenceville
Equal representation from:
Medical-Surgical Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

Commissioner's Physician Advisory Committee
(Representation requested by State Commissioner of Health to assist in the DRG concept—June 1977)

Alexander D. Kovacs, M.D., *President* ..... Scotch Plains
Douglas M. Costabile, M.D., *Chairman, Board of Trustees, President's Representative* ..... Murray Hill

Consumer Health Education, Advisory Committee of the Office of
(Representation requested by UMDNJ—1974)

Arthur Krosnick, M.D. ..... Trenton

Diabetes Coordinating Council
(Representation requested by Department of Health—November 10, 1980)

Arthur Krosnick, M.D. ..... Trenton

Diet Manual Revision Committee, New Jersey Department of Health
(Representation requested by Department of Health—September 27, 1982)

J. McNeill Gibson, M.D. ..... Trenton

DRG Position Ad Hoc Committee on Presentation of MSNJ
(Established by Board of Trustees—December 19, 1982)

Alfred A. Alessi, M.D., *Co-Chairman* ..... Hackensack
Frank J. Primich, M.D., *Co-Chairman* ..... West New York
Stanley S. Bergen, Jr., M.D. ..... Newark
John P. Capelli, M.D. ..... Haddonfield
James E. George, M.D., J.D. ..... Woodbury
Edwin W. Messey, M.D. ..... Willingboro
Myles C. Morrison, Jr., M.D. ..... Morristown
Gerald H. Rozan, M.D. ..... Wayne
Howard D. Slobodien, M.D. ..... Metuchen

Education, State Department of
(Liaison requested by Assistant Commissioner of Education—September 21, 1958)

Glenn P. Lambert, M.D., *Chairman, Special Committee on Child Health* ..... Flemington

Epilepsy, Advisory Panel to State Director of Motor Vehicles
(Established at request of Director of Motor Vehicles—July 29, 1966)

J. Berkeley Gordon, M.D. ..... Rumson

Executive Committee
(Provided in Bylaws, Chapter III (c))

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Graduate Medical Education, Advisory Council on
(Representation requested by UMDNJ—1979)

Edwin W. Messey, M.D. ..... Willingboro

Health Care Administration Board
(Representative appointed by MSNJ—1976)

Edward A. Schauer, M.D., *Second Vice-President* ..... Farmingdale

Health Maintenance Organization Projects, Advisory Committee To Participate in the Review of
(Recommended to Executive Director, State Health Coordinating Council, Department of Health—1974)

Henry J. Mineur, M.D. ..... Westfield

Health Professionals Education Advisory Council
(At the request of Department of Higher Education—to serve two years beginning August 1983)

William J. D'Elia, M.D. ..... Spring Lake

Health Research and Educational Trust of New Jersey (HRET) Policy Advisory Committee
(Participation in HRET Telecommunications Network approved by Board of Trustees—February 13, 1983; representation requested—April 1983

Douglas M. Costabile, M.D., *Chairman, Board of Trustees* ..... Murray Hill

Health Sciences Group, New Jersey
(Membership requested by Health Sciences Group—January 19, 1975)

Edward G. Bourns, M.D. ..... Jamesburg
Paul J. Hirsch, M.D., *Treasurer* ..... Bridgewater
Bernard A. Rineberg, M.D. ..... New Brunswick

Health Sciences Group Legislative Affairs Committee, New Jersey
(Liaison requested by Health Sciences Group—November 16, 1975)

Irving P. Ratner, M.D., *Chairman, Council on Legislation* ..... Willingboro

Hospital Association, New Jersey
(Liaison established at request of NJHA—December 17, 1967)

Frank Y. Watson, M.D., *President-Elect* ..... Glen Ridge

Hospital Advisory Council, State Department of Health
(Appointed by Commissioner of Health—1973)

Nicholas E. Marchione, M.D. ..... Vineland

Hypertension Study Group
(Department of Health—1979)

David Brailovsky, M.D. ..... Westfield

JEMPAC, Conference Committee with
(Established at request of JEMPAC—June 25, 1967)

Irving P. Ratner, M.D., *Chairman, Council on Legislation* ..... Bayonne
Joseph W. Fleisher, M.D., *Chairman, Council on Medical Services* ..... Bayonne
Edward A. Schauer, M.D., *Second Vice-President* ..... Farmingdal

Legislation

(1) Federal Keyman
(Mechanism established by MSNJ—April 4, 1954—to serve as of ficial intermediaries between MSNJ and federal legislators)
14 Congressional District Keymen
2 Senatorial Keymen
(2) State Keymen
(Mechanism established by MSNJ—July 13, 1952)
Keymen in 40 Legislative Districts/21 Component Societies

Medical Assistance Advisory Council
(At request of New Jersey Department of Human Services—1980

James Q. Atkinson, M.D. ..... Vincentow

Medical Assistants, State of New Jersey, Inc., American Association of
(Liaison requested by Association—September 15, 1963)

Giovanni Lima, M.D. ..... Kearny

Medical Liaison Committees
(High-level conference groups for discussion and consideration o items of mutual interest)

Alexander D. Kovacs, M.D., *President* ..... Scotch Plains
Frank Y. Watson, M.D., *President-Elect* ..... Glen Ridge
Ralph J. Fioretti, M.D., *First Vice-President* ..... Rochelle Park
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Arthur Bernstein, M.D., *Secretary* ..... South Orange
Paul J. Hirsch, M.D., *Treasurer* ..... Bridgewater
Vincent A. Maressa, *Executive Director* ..... Lawrenceville

(1) **Medical-Dental**
(Liaison requested by Dental Society—June 10, 1951)
(2) **Medical-Hospital**
(Liaison established by MSNJ—October 25, 1953)
(3) **Medical-Legal**
(Liaison established by MSNJ—October 25, 1953)
(4) **Medical-Nursing**
(Liaison established by MSNJ—April 4, 1954)
(5) **Medical-Osteopathic**
(Liaison requested by Osteopathic Association—September 17, 1961)
(6) **Medical-Pharmaceutical**
(Liaison established by MSNJ—July 26, 1953)

Medicare Peer Review Committee
(Established by Board of Trustees, December 20, 1970, at request of fiscal intermediary. The Committee will review and evaluate claims involving questions of over-utilization under Medicare. The composition of the Committee includes six groups of three members each in the fields of family practice, general surgery, orthopedic surgery, internal medicine, ophthalmology, and urology.)

Middlesex County Tercentennial
(Liaison requested by Middlesex County—November 21, 1982)

Arthur Krosnick, M.D. ..... Trenton
Morris H. Saffron, M.D. ..... New York

Pharmaceutical Assistance to the Aged and Disabled Advisory Council
(Appointed by Commissioner of Department of Human Services: physician representation requested by Division of Medical Assistance—December 19, 1980)

Frank J. Malta, M.D. ..... Toms River

Pharmacopeial Convention, The United States
(MSNJ invited to appoint a delegate to serve five-year-term—August 1980)

Frank J. Malta, M.D. ..... Toms River

Physician Jury Service, Ad Hoc Committee on
(Appointed by President, pursuant to resolution adopted by 1983 House of Delegates)

L. Arne Skilbred, M.D., *Chairman* ..... Glen Ridge
John J. Crosby, Jr., M.D. ..... Jersey City
Howard J. Lehr, M.D. ..... Fanwood
Irving P. Ratner, M.D. ..... Willingboro
Bernard A. Rineberg, M.D. ..... New Brunswick

Poison Information and Education System, Advisory Board to New Jersey
(Representation requested by Department of Health—January 21, 1983)

Rudolf E. Schwaeble, M.D. ..... Mendham

Prescription Abuse Avoidance Committee
(Representation requested by State Board of Medical Examiners—April 14, 1983)

David I. Canavan, M.D. ..... Lawrenceville
Daniel Greenfield, M.D. ..... Piscataway

Radiation Protection, Advisory Committee to New Jersey Commission on
(Consultants in nuclear medicine appointed by Commission—November 20, 1966)

Henry J. Powsner, M.D. ..... Princeton

Radiation Protection, Consultant Serving New Jersey Commission on
(Nomination for appointment to Commission requested—March 17, 1963)

Frank Gingerelli, M.D. ..... Hackensack

Radiologic Technology Board of Examiners
(Agency of Commission on Radiation Protection, Department of Environmental Protection, appointed by Governor—1983)

Armando F. Goracci, M.D. ..... Woodbury

Relief of Families of Physicians in NJ, Society for the
(Liaison requested by Society—May 17, 1959)

Joseph R. Jehl, M.D. ..... Clifton

Resolutions, Committee on Annual Meeting
(Established by Board of Trustees to review all resolutions in advance of Annual Meeting—July 18, 1971)

Augustus L. Baker, Jr., M.D., *Chairman* ..... Dover
Armando F. Goracci, M.D. ..... Woodbury
Howard D. Slobodien, M.D., *Immediate Past-President* ..... Metuchen

Safety Council, New Jersey State
(Provided in Council Bylaws—1962)

Alexander D. Kovacs, M.D., *President* ..... Scotch Plains
George P. Bisgeier, M.D., *President's Representative, Chairman, Special Committee on Occupational Health, Worker's Compensation, and Rehabilitation* ..... Newark

Specialist, Ad Hoc Committee To Determine the Definition of a
(Established by Board of Trustees—June 12, 1983)

Alexander D. Kovacs, M.D., *President, Chairman* ..... Scotch Plains
Joel S. Cherashore, M.D. ..... Nutley
Douglas M. Costabile, M.D., *Chairman, Board of Trustees* ..... Murray Hill
Palma E. Formica, M.D. ..... New Brunswick
Paul J. Hirsch, M.D., *Treasurer* ..... Bridgewater
Representation from NJ Association of Medical Specialty Societies

State Board of Medical Examiners
(Trustees designated to attend monthly meetings on rotating basis, per Board of Trustees—December 15, 1974; per Board of Trustees—August 8, 1979)

Frank Y. Watson, M.D., *President-Elect* ..... Glen Ridge
Martin E. Johnson, *Staff Member* ..... Lawrenceville

Statewide Health Planning and Coordinating Council (SHCC) and/or Review Committee
(Liaison established—January 15, 1978)

Ralph J. Fioretti, M.D., *Second Vice-President* ..... Rochelle Park*
*Dr. Fioretti will serve in this capacity until he becomes President, at which time the new Second Vice-President will serve as his replacement.

Student Association, Medical Society of New Jersey
(Formed—July 17, 1977)

Palma E. Formica, M.D. ..... New Brunswick
Nancy Mao, *Student* ..... New Brunswick
Ben Wilfond, *Student* ..... Piscataway

University of Medicine and Dentistry of New Jersey, Foundation of the
(MSNJ representative appointed yearly by Board of Trustees to serve as trustee, pursuant to Bylaws of the Foundation—1979)

Arthur Bernstein, M.D., *Secretary* ..... South Orange

Women Membership, Ad Hoc Committee on
(Established by Board of Trustees—December 19, 1982)

Carolyn W. Watson, M.D., *Chairman* ..... Glen Ridge
Roberta G. Rubin, M.D., *Vice-Chairman* ..... Pompton Plains
Vivian Chen, M.D. ..... East Brunswick
Janet Geraghty-Deutsch, M.D. ..... Jersey City
Birute S. Preikstas, M.D. ..... Oakhurst

Statement of Ownership, Management, and Circulation

(Required by 39 U.S.C. 3685)

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7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding one percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.): Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648 (a nonprofit corporation of New Jersey).

8. Known bondholders, mortgages, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities: none (a nonprofit corporation of New Jersey).

9. For completion by nonprofit organization authorized to mail at special rates (Section 411.3, DMM only). The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes have not changed during preceding 12 months.

10. Extent and nature of circulation:

Extent and nature of circulation	Average no. copies each issue during preceding 12 months	Actual no. of copies of single issue published nearest to filing date
A. Total no. copies printed (net press run)	10,400	11,500
B. Paid Circulation		
1. Sales through dealers and carriers, street vendors, and counter sales	—	1,300
2. Mail subscriptions	9,806	9,605
C. Total paid circulation (sum of B1 and B2)	9,806	10,905
D. Free distribution by mail carrier or other means—samples, complimentary, and other free copies	370	371
E. Total distribution (sum of C and D)	10,176	11,276
F. Copies not distributed		
1. Office use, left-over, unaccounted, spoiled after printing	224	224
2. Return from new agents	—	—
G. Total (sum of E, F1, and 2—should equal net press run shown in A)	10,400	11,500

11. I certify that the statements made by me above are correct and complete.

(signed) Arthur White
Director of Finance and Administrative Services

12. For completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual). 39 U.S.C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates." In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the phased postage rate presently authorized by 39 U.S.C. 3626 (signed).

Trustees' Minutes September 18, 1983

A regular meeting of the Board of Trustees was held on Sunday, September 18, 1983, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . .

(1) Health Policy Agenda for the American People Advisory Committee Meeting . . . Received as informative a written report of the Health Policy Agenda Advisory Committee Meeting; the purpose of the agenda is to develop a long-term, consistent approach to health care in the United States.

(2) JEMPAC . . . Noted that contributions to the emergency legislative campaign fund (MedAC) were being received.

Report of the Executive Director . . .

(1) NJ Department of Health Blue Ribbon Committee . . . Empowered MSNJ's Executive Committee to meet with the NJ Association of Medical Specialty Societies to develop a policy on the proposed recommendations of the Department of Health Blue Ribbon Committee; the MSNJ position then will be discussed with the NJ Hospital Association in an effort to reach a consensus.

(2) Determination of Core Facility for Corporate Unbundling . . . Noted that Dr. Kovacs appointed Dr. Watson to serve on the Statewide Health Coordinating Council to establish a definition of "core hospital."

(3) NJ Department of Health—Medical Staff Regulations . . . Agreed to cosponsor a seminar with the NJ Hospital Association relative to accreditation and hospital survey and licensing. Suggested that the following groups be invited: Joint Commission on Accreditation of Hospitals, MSNJ, NJ Hospital Association, AMA, Health Care Administration Board, and NJ Department of Health.

(4) MSNJ Financial Statements . . . Reviewed and approved the financial statements for the periods ending June 30, July 31, and August 31, 1983.

(5) Litigation . . .

(a) State Board of Medical Examiners vs. Strauch and Aluri . . . Noted that argument in the appellate division was scheduled for September 21, 1983, and a decision is expected 30 to 60 days thereafter.

(b) Subordinated Loan Deductibility . . . Noted that the trial date is set for October 13, 1983.

(6) Appointment of Additional Member to Special Committee on Long-Range Planning and Development . . . Approved the following recommendation:

That the Board appoints L. Arne Skilbred, M.D., as a member of the Special Committee on Long-Range Planning and Development for a three-year term.

(7) Legislation . . .

(a) No-Fault Insurance . . . Was advised that amendments to the no-fault insurance legislation suggested by MSNJ have been added to the Senate version of the bill and approved by legislators sponsoring the bill and the Governor's Council.

(b) Physical Therapist Licensing Act of 1983 . . . Directed the NJ Society of Physical Medicine and Rehabilitation be requested to suggest appropriate nominees for appointment to the State Board of Physical Therapy.

Ad Hoc Committee on Presentation of MSNJ DRG Position . . . Approved the response to the State Commissioner of Health suggesting a discussion group meet to evolve a means of an ongoing dialogue with all matters of mutual interest.

Committee on Annual Meeting . . .

(1) 1984 Daily Schedule . . . Approved the following proposal, with the stipulation that the opening session of the House of Delegates precede the meetings of the Reference Committees:

The Annual Meeting is to be held in Atlantic City beginning on Thursday, May 3, 1983, and ending on Sunday, May 6, 1983.

(2) Scientific Sessions and Scientific Section Programs . . . Approved the following recommendation:

That the Board of Trustees approves the policies governing scientific sessions and the time schedule for the scientific section programs, as supplied by the Committee on Annual Meeting.

(3) Change in Name of Section on Rheumatism . . . Approved the following recommendation:

That the name of the Scientific Section on Rheumatism be changed to the Section on Rheumatology.

(4) Commendation to Former Committee Chairman . . . Voted unanimously to commend Ralph J. Fioretti, M.D., for his many years of service as Chairman of the Committee on Annual Meeting.

Committee on Drug and Alcohol Abuse . . . Approved the following recommendation on drunken driving:

Resolved, that MSNJ supports legal means to remove intoxicated drivers (both alcohol and drug abusers) from the road because they are a public health hazard; and be it further

Resolved, that MSNJ alerts physicians treating injury cases that substance abuse (alcohol and other drugs) may be the underlying cause in auto accident injuries; and be it further

Resolved, that MSNJ reminds physicians that substance abuse is a treatable illness and that it is their duty to refer such individuals to appropriate treatment programs; and be it further

Resolved, that MSNJ urges school physicians to develop educational programs in cooperation with their local board of education that will promote understanding of the conflict between intoxication and driving; and be it further

Resolved, that this resolution be forwarded to the AMA for its approval and national implementation.

Audit Committee . . . Approved the following recommendation:

That the Board of Trustees accepts the re-

port of the audit of the financial statements of the Society.

Special Committee on Long-Range Planning and Development . . .

(1) Commendation of Former Chairman . . . Expressed gratitude and appreciation to William J. D'Elia, M.D., for his leadership as Chairman.

(2) Resident Membership . . . Approved the following recommendation and referred it to the Committee on Revision of Constitution and Bylaws:

That county societies consider making their resident members an integral part of their society functions, including that of delegate to MSNJ.

(3) Board Referral . . . Approved the following recommendation and suggested that the Committee on Long-Range Planning and Development may wish to pursue further discussion on the modus operandi of the Nominating Committee as well as a broader exposure of candidates seeking national office:

That in the selection of candidates for AMA delegate and alternate delegate, the Nominating Committee should consider the ability of the individual to articulate the policy of MSNJ and the sentiments of the membership, and also should consider the candidate's potential for participating in a leadership position at the national level.

Note: Adoption of the recommendation does not supersede the tenure requirement imposed by the Bylaws. It is merely intended as an advisory to the Nominating Committee.

(4) Representation in MSNJ House of Delegates . . . Approved the following recommendation:

That membership and delegate status for medical school faculty members be continued at the county level.

(5) Chairman of the Board of Trustees . . . Approved and referred to the Committee on Revision of Constitution and Bylaws the following recommendation:

That the President of the Medical Society of New Jersey serves as Chairman of the Board of Trustees.

(6) MSNJ Position on DRGs . . . Approved the following recommendation:

That MSNJ upholds its conviction and continues to oppose the DRG system of reimbursement through educational techniques to be developed by the Ad Hoc Committee on Presentation of MSNJ DRG Position.

Executive Committee Meeting with NJ Business Group . . .

DRGs . . . Approved a recommendation which will resolve the following questions: Is the DRG program cost-effective? What is its impact on the quality of care? The expenditure of funds for this report to receive prior Board authorization.

New Business . . .

Support for Establishment of Two PROs in New Jersey . . . Voted to petition the Health Care Financing Administration to designate two PROs (Peer Review Organizations) in New Jersey.

President's Column

Alexander D. Kovacs, M.D.

Does the increasing frequency of malpractice suits make you frustrated and paranoid? I feel frustrated by malpractice suits.

It seems the more we do to make people healthier and to live longer, the more we are sued! Physicians are caught in a conflict between the preservation of life and a reparation system that destroys the physician while healing the patient.

We try to get tort laws changed. In some states, physicians have succeeded, only to have the courts and judges knock them down; hence we begin all over again.

A recent medical malpractice claim report by the Rand Institute of California* found the following:

1. A plaintiff is more likely to win an award if the injury is permanent rather than temporary and an award is most likely if the injury is fatal.

2. A plaintiff has a 50 percent higher chance of winning; res ipsa loquitur.

3. A plaintiff is 20 percent less likely to win if he charges the diagnosis and 34 percent less likely if he alleges lack of informed consent.

4. A plaintiff is almost twice as likely to win against multiple defendants as versus a single defendant.

5. A plaintiff does not have a significantly higher chance of winning in surgery-related cases than in others.

6. The size of the award is strongly influenced by the severity of the injury.

7. The higher the economic loss, the higher the award.

8. The potential verdict for claims involving total permanent disability is roughly double for claims involving death.

9. Potential verdicts for total permanent disease increase approximately 2 percent for each year of life expectancy.

10. The awards for minor injuries, temporary or permanent, are not systematically related to severity, but rise and fall with the age of the claimant, peaking at age 30.

The frequency of claims is beginning to rise again despite a reduction in the flow of injuries as a result of more careful practice and more quality control on the part of providers. It is my belief that there are three more components to the malpractice claim problem and we must attack all three: lack of tort reform in New Jersey; the role of the legal profession; and failure of good practice on the part of physicians.

Let us examine the role of the legal profession. The New York State Court of Appeals ruled that a lawyer cannot be held liable for damage to a doctor's reputation even if that lawyer acted maliciously and unethically in filing a baseless medical malpractice suit. The rationale is the fear of throwing a "chilling effect" on the right of an individual to sue. Evidently, doctors have no right to protect themselves from the "chilling effect" of a baseless suit.

There simply are too many law schools and too many underemployed lawyers. Perhaps a commission should be created similar to the 1910 Flexner commission for medical schools to evalute law schools to ascertain their fitness to teach law. I believe this would bring about much-needed reforms in the legal profession and certainly would be a significant step toward a solution of the litigation epidemic. There appears to be no requirement for continuing legal education and no review committee to judge quality of work and standards of practice for lawyers and judges.

The preponderance of lawyers in the legislature has made any change in tort law extremely difficult. The legal profession's accusation of a medical monopoly and the drama of their position that plaintiffs must have their day in court are self-serving rhetoric. Their position as patient advocate is a false one. We must try individually and as a group to educate our patients to this fact. Only an informed and outraged public can force changes in the law and lessen the impact of this unique social crisis. We must step up our attack against unbridled litigation and kindle public unity against misuse.

We must alert the public to the fact,

*Rand Institute of California: Frequency and severity of medical malpractice claims. Rand Institute of Civil Justice, Santa Monica, California, 1983.

via our public relations firm, that lawyers get 30 to 40 percent of a court award after expenses are paid. We also should inform them high jury awards for sympathy increase the cost of health care. It is in the public interest to support our fight against unbridled malpractice claims since they are the ultimate payors of such awards and the true beneficiaries are the lawyers.

The program of negligence on the part of the physician is twofold: medical negligence and legal negligence. All of us have a responsibility to watch out for medical negligence by our colleagues. It is damaging to all of us and certainly detrimental to the patient. As abhorrent as the new "snitch law" is, perhaps intervention by the New Jersey State Board of Medical Examiners is the only answer for those few physicians who will not or cannot practice medicine according to accepted standards. Most of us, however, are guilty of legal negligence. We get into trouble because we do not know the law. We cannot become lawyers but we ought to learn enough to protect ourselves. I would like to see the Medical Inter-Insurance Exchange or MSNJ offer a course in medical law with the reward of a reduction in premium to those physicians who successfully complete the seminar.

Society and patients must be protected. Medicine must be free from the bondage of litigious threats that force us to practice costly and counterproductive defensive medicine. The future appears ominous but with dignity, compassion, and empathy for patients, we shall prevail. The ultimate winner will be the patient.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

Dr. Richard C. Reynolds has assumed the position of acting executive vice-president of the University of Medicine and Dentistry of New Jersey. He also is continuing his assignment as dean of UMDNJ-Rutgers Medical School. The University is fortunate to have a person of Dr. Reynolds's capacity to assume responsibility during this interim period.

Since arriving at UMDNJ five years ago from the University of Florida College of Medicine, Dr. Reynolds consistently has demonstrated excellence as a leader, academician, and administrator. Under his stewardship, the complex plan to establish a clinical campus at Middlesex General-University Hospital, New Brunswick, became a reality. As affiliation with Middlesex General-University Hospital developed, so did the recruitment and retention of the school's outstanding faculty from across the country, making possible new academic programs—like those in geriatrics, family practice, and environmental medicine—that have made the school a pacesetter in medical education.

The research program at UMDNJ-Rutgers Medical School has advanced in the same laudable way, and our enhanced understanding of such areas as Parkinson's disease, collagen-related abnormalities, and heart disease is evidence of satisfying progress in research.

The high quality of medical education and research under Dean Reynolds's leadership translate naturally into better diagnosis and treatment of patients, particularly in specialized areas, at Middlesex General-University Hospital and other hospitals affiliated with UMDNJ-Rutgers Medical School.

Also during his tenure, the UMDNJ-Rutgers Medical School, Camden, has begun to take shape in affiliation with Cooper Hospital/University Medical Center.

Programs in environmental health and community medicine are being strengthened through a three-year $75,000 grant to UMDNJ from the New Jersey companies of AT&T: New Jersey Bell Telephone Company, Bell Laboratories, American Telephone and Telegraph Company, and AT&T Long Lines.

Presented through the Foundation of UMDNJ, a private, nonprofit corporation committed to the advancement of the University, the AT&T grant is earmarked for the development of the educational health care and research efforts of the Department of Environmental and Community Medicine of UMDNJ-Rutgers Medical School, Piscataway, which is chaired by Bernard D. Goldstein, M.D.

Now in its fourth year, the department has taken long strides in establishing the University as a center for environmental medicine. Its accomplishments include development of an occupational medicine curriculum for medical students, a mini-residency course for physicians, industrial hygiene and educational programs for the State Department of Environmental Protection, and an outpatient clinic for environmental and occupational medicine at Middlesex General-University Hospital, New Brunswick.

The state's first graduate program in public health, offered jointly with Rutgers, the state university, began in September. A postgraduate residency program for physicians specializing in occupational medicine will begin in 1984.

The UMDNJ-New Jersey Medical School has received its 13th institutional research grant from the American Cancer Society. The $25,000 fund will be allocated on a competitive basis to faculty members of the Newark-based school to help initiate basic and clinical cancer research. For projects whose initial results show promise, more substantial funding will be sought. Since 1970, more than 100 pilot projects on the causes, properties, and treatment of cancer have been started with ACS institutional grants.

MSNJ Auxiliary

Gale Wayman
President

In recent years, the Auxiliary has concentrated its efforts on various health projects. These projects not only stimulate the interest of our members in the Auxiliary but also have become a wonderful public relations tool for the Medical Society. They show the public that the medical community is not just interested in its own welfare but is interested in promoting better public health.

Every county auxiliary is encouraged to participate in the health project most needed in its own community. The AMA Auxiliary and the State Auxiliary will provide information and assistance with various projects.

This year the AMA Auxiliary is continuing its "Shape Up for Life" campaign by promoting awareness and prevention of child abuse and drunken driving. Packets and brochures are available to counties on "Child Abuse Prevention" and "Drinking and Driving."

Our State Auxiliary cosponsored "Eye Health Screening" Week this past September and auxiliary members across the state worked on this program and many others that improve public health, through immunization programs, disease screenings, educational programs, and working on legislative action that affects health.

We are your "Ambassadors of Good Will." Let us help you put your best image forward. Please help by supporting your own county auxiliary project!

AMNJ Report

Paul J. Hirsch, M.D.
President

The Academy of Medicine's *Annual Calendar* of continuing medical education in New Jersey has been distributed. This 40-page book, indexed by specialty, is mailed to all members of the Academy of Medicine and to medical libraries and directors of medical education in New Jersey. It will be supplemented during the year with mailings and announcements of special programs.

A program added to our schedule was a talk, "Recent Developments in Antiarrhythmic Drug Therapy," by Miles Vaughan Williams, M.D., D.S.C., professor of pharmacology at Oxford University; the talk was presented on September 29, 1983, at The Manor, West Orange.

The first in our series of "First Wednesday at the Academy," programs was presented on October 5 at MSNJ/Academy headquarters. The speaker was William Toby, regional administrator of HCFA.

Our search for a new executive staff member, associate director for continuing education, continues under the guidance of Dr. Alfred Alessi and Mr. Charles Heitzmann. We believe that filling this new position will allow the Academy to initiate new services for the medical community of New Jersey.

The first issue of our newsletter recently has been distributed to members of the Academy. Dr. Thomas Witomski is the new editor.

Our new computerized program to record CME credits earned by Academy members has been initiated. This service is provided without charge to members and will be made available to nonmembers for $20 a year. More than 300 physicians have registered for this program thus far. Members will receive a computerized print-out of all CME credits earned every six months.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

CARDIOLOGY—Rakesh Kumar Gupta, M.D., P.O. Box 1452, Paintsville, KY 41240. All-India Institute of Medical Sciences 1975. Also, internal medicine. Solo hospital-based, group. Available.

Aubrey Orrin Lewis, M.D., 200 Carman Ave., Apt. 21-F, East Meadow, NY 11554. SUNY-Syracuse 1979. Also, general internal medicine. Board certified (IM). Solo, partnership, group, academic (cardiology). Available July 1984.

FAMILY MEDICINE—Rabie Glenoa, M.D., 105 Trenton Rd., Overbrook Hills, PA 19151. Cape Town (South Africa) 1977. Part-time family practice or emergency room. Available.

Jan D. Janeff, M.D., 168 Loomis Ct., Princeton, NJ 08540. Sofia (Bulgaria) 1953. Board eligible. Group or partnership. Available.

David Neidorf, M.D., 1701 Taxville Rd., Apt. 7A, York, PA 17404, SUNY-Stony Brook 1981. Board certified. Group, partnership, HMO. Available August 1984.

GASTROENTEROLOGY—Richard C. Dai, M.D., 16 Kenmar Dr., Apt. 127, Billerica, MA 01821. Chicago Medical School 1978. Also, internal medicine. Board certified (IM). Group or partnership. Available July 1984.

Joel Chodos, M.D., 3450 Wayne Ave., Bronx, NY 10467. Columbia 1975. Board certified. Also, general internal medicine. Group, partnership, hospital. Available July 1984.

INTERNAL MEDICINE—Richard Eanni, M.D., 19 Fernandez Ave., New Windsor, NY 12550. Rome (Italy) 1972. Also, nephrology. Board eligible. Solo (assuming practice from retiring physician) or partnership. Available.

Leonard H. Kanterman, M.D., 1405 Givens Rd., Manhattan, KS 66502. SUNY-Downstate 1977. Subspecialty, endoscopy. Board certified. Group or partnership. Available July 1984.

J. Walter Sledge, M.D., 2115 Bedford Way, Columbia, SC 29209. University of Alabama School of Medicine 1978. Board certified. Group, partnership, solo. Available June 1984.

Richard C. Dai, M.D., 16 Kenmar Dr., Apt. 127, Billerica, MA 01821. Chicago Medical School 1978. Also, gastroenterology. Board certified. Group or partnership. Available July 1984.

Rakesh Kumar Gupta, M.D., P.O. Box 1452, Paintsville, KY 41240. All-India Institute of Medical Sciences 1975. Also, cardiology. Solo, hospital-based, group. Available.

Patricia M. Romano, M.D., 1077 River Rd., N608, Edgewater, NJ 07020. Cornell University Medical College 1979. Also, pulmonary. Board certified. Group. Available July 1984.

Laurence M. Silverstein, M.D., 500 Ave. G, #7, Redondo Beach, CA 90277. Albert Einstein 1979. Board certified. Available.

Yi-po Wu, M.D., 32 Hapgood Way, Shrewsbury, MA 01545. National Taiwan University Medical College 1972. Board eligible. Group or partnership.

Arvind Mehta, M.D., 8051 N. Hanover St., Anaheim, CA 92861. Seth G.S. Medical College (India) 1975. Also, nephrology. Board eligible. Solo, group, associate. Available December 1983.

Elliott Friedman, M.D., 25 Penny La., Baltimore, MD 21209. SUNY-Syracuse 1978. Subspecialty, endocrinology. Board certified—IM; board eligible—endocrinology. Group or partnership (both specialties). Available July 1984.

NEPHROLOGY—Richard Eanni, M.D., 19 Fernandez Ave., New Windsor, NY 12550. Rome (Italy) 1972. Also, general internal medicine. Board eligible (IM). Solo (assuming practice from retiring physician) or partnership. Available.

Arvind Mehta, M.D., 8051 N. Hanover St., Anaheim, CA 92861. Seth G.S. Medical College (India) 1975. Also, internal medicine. Board eligible. Solo, group, partnership. Available December 1983.

NEUROLOGY—Elizabeth Kamenar, M.D., 12701 Shaker Blvd., Apt. 410, Cleveland, OH 44120. Ohio State 1975. Board eligible. Group, partnership, academia. Available July 1984.

Robert P. Rubens, M.D., 105 Ward St., Apt. 204, Seattle, WA 98109. UMDNJ-New Jersey Medical School 1980. Board eligible. Available July 1984.

OBSTETRICS/GYNECOLOGY—Gary B. Steinbach, M.D., 6913 Bonnie Ridge Dr., Baltimore, MD 21209. UMDNJ 1980. Board eligible. Group or partnership. Available June 1984.

Angela McVey, M.D., 3191 Agate St., Philadelphia, PA 19134. Bucharest Medical School (Rumania) 1949. Board eligible. Group, partnership, hospital, academia. Available.

Joseph Booker, Jr., M.D., 2500 Milvia St., Apt. 228, Berkeley, CA 94704. University of California-San Francisco 1973. Partnership, group, solo. Available.

Wook Chung, M.D., 2212 Watterworth Drive, Kalamazoo, MI 49008. Catholic Medical College (Korea) 1967. Board certified. Solo, group, partnership. Available.

Alan M. Askinas, M.D., 1309 Carrollton, Apt. 321, Metairie, LA 70005. Illinois 1980. Board eligible. Group, partnership, solo, part academic. Available July 1984.

OPHTHALMOLOGY—Steven R. Davis, M.D., 1000 Lakeview Rd., Clearwater, FL 33516. University of Alabama 1975. Board certified. Solo or association. Available.

Tariq Saeed, M.D., 6906 Spourse Ct., Springfield, VA 22153. Liaquat (Pakistan) 1968. Board eligible. Group, partnership, solo. Available.

PATHOLOGY—Farhad Setoodeh, M.D., 41 Wild Duck Rd., Wyckoff, NJ 07481. Jandishapur 1971. Board certified. Group or partnership. Available.

PEDIATRICS—Howard Mintz, M.D., 60 Presidential Plaza, Apt. 308, Syracuse, NY 13202. Pittsburgh 1981. Board eligible. Group or partnership. Available July 1984.

PULMONARY DISEASES—M. Zaslow, M.D., 24 Westgate Rd., Chestnut Hill, MA 02167. Harvard 1977. Also, general

internal medicine. Board certified (IM); board eligible (PM). Any type practice. Available.

Patricia M. Romano, M.D., 1077 River Rd., N608, Edgewater, NJ 07020. Cornell University Medical College 1979. Also, internal medicine. Board certified (IM). Group. Available July 1984.

James Kohan, M.D., 19 Highmanor Dr., Henrietta, NY 14467. Virginia 1979. Also, general internal medicine. Board certified (IM). Group, partnership, solo, institutional. Available July 1984.

RADIOLOGY/NUCLEAR MEDICINE—Conrad P. Ehrlich, M.D., 1243 Beacon St., Apt. 3-B, Brookline, MA 02146. Boston 1976. Board certified (also IM). Group or partnership. Available July 1984.

RHEUMATOLOGY—Richard Furie, M.D., 435 E. 70th St., Apt. 8-F, New York, NY 10021. Cornell 1979. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1984.

SURGERY, GENERAL—Carlos A. Ferrari, M.D., 741 E. Tuscarawas, Barberton, OH 44203. Univ. National of Cordoba (Argentina) 1972. Board certified. Solo, small group, partnership. Available.

Kothari Mayur, M.D., 950 49th St., Apt. 8-F, Brooklyn, NY 11219. Addisababa (Africa) 1974. Also, vascular surgery. Board eligible. Group. Available.

Jayesh R. Modi, M.D., 740 N. Bruns La., Springfield, IL 62702. Surat (India) 1974. Also, vascular surgery. Board eligible. Partnership or solo. Available.

Ramon J. Gomez, M.D., 40-71 Gleane St., Elmhurst, NY 11373. University of the East (Philippines) 1978. Group or hospital-based emergency medicine practice. Available.

SURGERY, ORTHOPEDIC—Jeffrey H. Charen, M.D., 155 Lexington St., Apt. 15, Auburndale, MA 02166. Rochester 1978. Board eligible. Group, partnership, solo (central or northern NJ preferred). Available January 1984.

Oscar A. Reicher, M.D., 71 Brookwood Ter., Nashville, TN 37205. Pittsburgh 1979. Solo or group. Available July 1984.

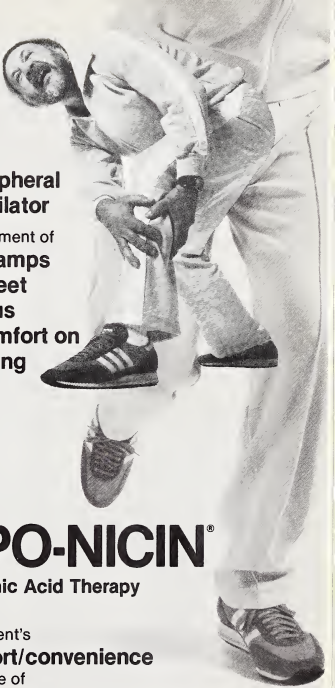
Richarard Lebovicz, M.D., 415 Grand St., New York, NY 10002. SUNY-Downstate 1979. Group or partnership. Available July 1984.

SURGERY, VASCULAR—Kothari Mayur, M.D., 950 49th St., Apt. 8-F, Brooklyn, NY 11219. Addisababa (Africa) 1974. Also, general surgery. Board eligible. Group. Available.

Jayesh R. Modi, M.D., 740 N. Bruns La., Springfield, IL 62702. Surat (India) 1974. Also, general surgery. Board eligible. Partnership or solo. Available.

UROLOGY—Gary Neal Dunetz, M.D., 310 LaGrange St., Chestnut Hill, MA 02167. SUNY-Upstate 1977. Group, partnership, multispecialty group. Available July 1984.

Barlow S. Lynch, M.D., 5145 Linda Lou Dr., Carmichael, CA 95608. SUNY-Buffalo 1977. Board eligible. Partnership, group, solo, academic. Available July 1984.



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Thiamine HCL (B-1) . . . . . 25 mg.
Riboflavin (B-2) . . . . . 2 mg.
Pyridoxine HCL (B-6) . . . . . 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN® /100 mg.

Each blue tablet contains:
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Ascorbic Acid . . . . . 150 mg.
Thiamine HCL (B-1) . . . . . 25 mg.
Riboflavin (B-2) . . . . . 2 mg.
Pyridoxine HCL (B-6) . . . . . 10 mg.
DOSE: 1 to 5 tablets daily.
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Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

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MEDICAL PHILATELY

The Path To Modern Medicine

JOSEPH H. KLER, M.D., New Brunswick

GREEK MEDICINE

Hippocrates (460-377 B.C.), born on the island of Cos, received his first medical instruction from his father and gained further experience by extensive travel. His achievements were as remarkable as those of his contemporaries living in the glorious age of Pericles.

Hippocrates not only separated medicine from philosophy but also from the mysticism of Aesculapian practices when he fully established the art of clinical observation and inspection. In his hands, medicine became an art, science, and profession. Hippocrates insisted that the course of disease was predictable and that there was nothing supernatural about it. All that is known of his work is contained in writings attributed to him. His description of many diseases, with few changes, can be used today.

He wrote on all phases of medicine—diagnosis as well as treatment. His greatest contribution is his medical philosophy expressed so well in the "Oath of Hippocrates" which epitomizes the ideal criterion of medical practice.



Hippocrates
Yemen, 1966

SURGERY

Emil Theodor Kocher, M.D., (1841-1917) was born, educated, and lived in Bern, Switzerland his entire life. He became one of the great surgeons of all time. He was a careful investigator and a meticulous operator.

Kocher was deeply interested in the thyroid gland and his contributions in this field earned him the Nobel Prize in 1909. He also was interested in neurological surgery, particularly in lesions of the spinal cord and in the problems of variations in intracranial pressure. He refined the transphenoidal operation for the removal of pituitary tumors. His book on neurosurgery, written in 1902, still is excellent.

Kocher devised many surgical instruments. He also contributed to military surgery, a great interest of his.



Kocher
Switzerland, 1967

Housing Application

218th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY

MAY 3-6, 1984

	Single	Twin	Suites
Resorts International (headquarters hotel)	$80.00	$80.00	$171/$250
Harrah's Marina Hotel Casino	$75.00	$75.00	
World International Hotel/Motel	$58.00	$58.00	
Lafayette Motor Inn	$58.00	$58.00	

Rates subject to 12% state and local taxes; tax subject to change.

All hotel reservations for the 218th Annual Meeting of MSNJ will be handled by the Atlantic City Convention Bureau. Please send your housing application with your 1st, 2nd, and 3rd choices directly to the Bureau, 16 Central Pier, Atlantic City, NJ 08401. All Delegates and Members are urged to make their hotel reservations early. Blocks of rooms will be available at Resorts International (headquarters hotel), Lafayette Motor Inn, World International Hotel/Motel, and Harrah's Marina Hotel Casino. The cut-off date for reservations will be April 6, 1984. Reservations cannot be guaranteed after this date. No Saturday arrivals please. All registrants will be charged for three nights: Thursday, Friday, and Saturday, May 3, 4, and 5, 1984.

MAIL THIS APPLICATION DIRECTLY TO THE ATLANTIC CITY CONVENTION BUREAU
16 Central Pier
Atlantic City, NJ 08401

Please list 1st, 2nd, and 3rd choices; confirmation will come directly from hotel.

1st Choice _____ 2nd Choice _____

3rd Choice _____

Accommodations desired: ☐ Single ☐ Twin ☐ Suite Parlor & 1 Bedroom
☐ Suite Parlor & 2 Bedrooms

Name _____

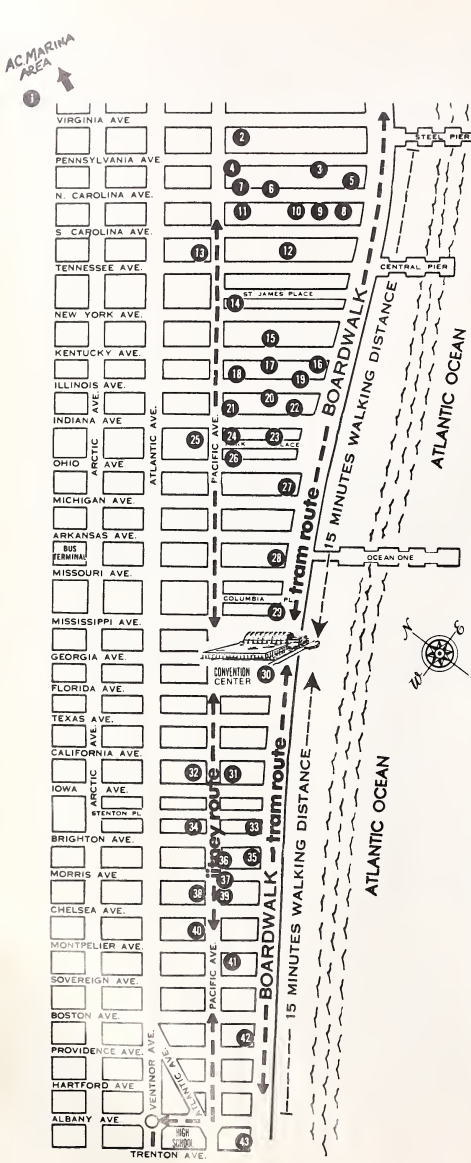
Address _____

City _____ State _____ Zip _____

Phone _____

Will arrive _____ (date) Time _____ Will depart _____ (date) Time _____

☐ Check if Official Delegate _____ County _____



INDEX TO MAP

1– HARRAH'S MARINA HOTEL CASINO
2 – ST. MORITZ
3 – ARISTOCRAT
4 – WORLD INTERNATIONAL HOTEL/MOTEL
5 – RESORTS INTERNATIONAL HOTEL-CASINO
6 – BARCLAY
7 – LAFAYETTE MOTOR INN
8 – CATALINA
9 – BARBIZON
10 – CAROLINA CREST
11 – BURGUNDY
12 – TRINIDAD
13 – FIESTA
14 – ENVOY
15 – ACAPULCO
16 – VILLAGE
17 – JEFFERSON
18 – SORRENTO
19 – CONTINENTAL
20 – BALA
21 – MIDTOWN
22 – SANDS HOTEL-CASINO
23 – CLARIDGE HOTEL CASINO
24 – BEST WESTERN INN
25 – EASTBOURNE
26 – MT. ROYAL
27 – BALLY'S PARK PLACE HOTEL-CASINO
28 – CAESARS BOARDWALK REGENCY HOTEL-C
29 – HARRAH'S BOARDWALK HOTEL
30 – PLAYBOY HOTEL-CASINO
31 – ASCOT
32 – ELDORADO
33 – TROPICANA HOTEL-CASINO
34 – DUNES
35 – DEAUVILLE HOTEL/MOTOR INN
36 – ALGIERS
37 – CASTLE ROC
38 – BARONET
39 – INTERNATIONAL
40 – FLAMINGO
41 – EL GRECO
42 – GOLDEN NUGGET HOTEL-CASINO
43 – LINCOLN BEACH

LETTERS TO THE EDITOR

Digital Subtraction Angiography

August 4, 1983

Dear Dr. Krosnick:

As authors of the article, "Digital Subtraction Angiography" which appeared in *The Journal* in March 1983, we feel compelled and qualified to respond to Dr. Kaufman's opinion in the July 1983 issue. We would have preferred publication of our response in the July issue, particularly since our images were reproduced and reinterpreted in Dr. Kaufman's commentary.

While we agree with some of Dr. Kaufman's points, we strongly disagree with others. Specifically, based on our accumulated experience of over 2,000 digital subtraction angiography (DSA) cases in 18 months, we believe: (1) in the large majority of patients, DSA can serve as the definitive study to evaluate the extracranial vasculature; (2) noninvasive vascular studies have a limited role and cannot predict reliably whether DSA will yield significant information; and (3) DSA may be requested by physicians other than vascular surgeons.

First, the accuracy of DSA must be assessed using catheter arteriography as the gold standard. Dr. Kaufman's discussion of underlying pathology and flow phenomena is appreciated but missed the point that DSA images often approach those of standard arteriography and in such cases can be interpreted accurately in the same manner. For example, arteriography would not differentiate whether the outpouching in our Figure 3 is ulceration into a plaque or hemorrhage under a plaque. This differentiation probably is not clinically important anyway; the image clearly depicts disease and, if symptoms warrant, surgery can be considered solely on the basis of DSA. At the Cleveland Clinic, where more DSA studies have been performed than anywhere else in the country, physicians have found that when the carotid bifurcations are well seen (80 percent of arteries examined), DSA is 97 percent accurate when compared with conventional arteriography.[1] Dr. Lusby, whose favorable experience with surgery based on DSA is quoted in Dr. Kaufman's article, is a surgeon at the University of California at San Francisco.[2] One would hope that these institutions would qualify as the "major centers" which Kaufman requests.

While noninvasive vascular studies have claims for a high degree of accuracy, their serious limitations must be addressed. Even large ulcers or total occlusions easily are missed.[3,4] A study by Turnipseed et al. at the University of Wisconsin, comparing noninvasive Doppler imaging with IV DSA in 36 patients, demonstrated significantly fewer false positive and false negative studies with DSA, using catheter arteriography as the standard.[5] Based on our experience of referrals from a wide group of practitioners throughout the state, noninvasive vascular screening tests often are grossly inaccurate. Too often patients have been referred for DSA with noninvasive studies indicating minimal plaque and DSA showing critical stenosis, or "hemodynamically significant stenosis" on noninvasive studies proved to be totally normal at DSA.

Referral of every patient to a vascular surgeon before DSA, as Dr. Kaufman advocates, neither is necessary nor cost effective. It would seem that neurologists, internists, ophthalmologists, and family practitioners are capable of determining whether a patient's symptoms or signs might reflect extracranial vascular disease. Does a patient with a normal carotid bifurcation really need to see a vascular surgeon? Should a patient with a falsely negative noninvasive study be denied a contrast study? Clearly not.

We believe that DSA is a step beyond the "infancy" that Dr. Kaufman describes. It is correct that the examination is highly dependent on patient cooperation and other factors such as cardiac output, but that diagnostic examinations are most frequently accomplished. For the smaller number of patients with less optimal examinations or in whom the resolution of selective arteriography is necessary to better define recognized lesions, catheter angiography obviously is required. However, when a lesion is defined clearly, catheter angiography simply is redundant; and when a lesion is excluded clearly, a more invasive examination is avoided.

Finally, DSA is a physician-intensive procedure and requires considerable experience both to determine the adequacy of a particular study and to interpret the results. Improper selection of frame-mask pairs either can "create" or "destroy" lesions, resulting in false positive or false negative interpretations. Unfortunately, DSA cannot make a vascular radiologist out of someone not actively involved in vascular radiology. For example, in our Figure 4A which Dr. Kaufman reinterpreted, the small defect in the left internal carotid artery distal to the pinpoint stenosis is artefactual (not a constant finding), rather than a thrombus as he suggested.

In order to be considered a viable modality, DSA must be more than another expensive screening test. We believe that if the examination is performed carefully in properly selected patients and interpreted by an experienced physician, it is highly accurate and allows rational decisions to follow. As these decisions often will ultimately be made by surgeons, it is important to recognize that the opinions of Dr. Kaufman are far from universal, even among his surgical colleagues.

Richard F. Mattern, M.D.
Kenneth L. Jewel, M.D.
Barry I. Loigman, M.D.
Steven D. Richman, M.D.
Charles C. Royer, M.D.
Charles A. Whelan, M.D.

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4. Anderson DC, Loewenson R, Yock D, et al.: B-mode, real-time carotid ultrasonic imaging: Correlation with angiography. *Arch Neurol* 40:484-488, 1983.

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Hair-Trigger Alert Era

September 6, 1983

Dear Dr. Krosnick:

This letter is in answer to Dr. Louria's commentary, "Consequences of Living in a Hair-Trigger Alert Era (August issue)."

Dr. Louria projects that the hair-trigger alert era will come in 1984 to 1985. Yet, we have been under this tension during the past 25 plus years. He and his confreres, by renewing what possibly may happen and how horrible the effects of a nuclear holocaust will be, do not make matters any better except to create hysteria.

I remember hearing these same arguments in the early 1960s when my children were small. They knew the world would end soon in a nuclear war—what should they live for (hippie era). Yet, they survived and happily are married and not into drugs.

Now, I am not belittling the potential consequences of nuclear war, and we should do all we can to avoid it; however, by frightening our people into submission, we play directly into the Soviet Union's hands with their disinformation campaign (as shown by defecting KGB agents).

With a reasonable person you may talk, debate, and try to convince—but who decided that the Soviets are reasonable when they have broken all their treaties bar none (except if it suits their purposes for further world conquest)? The only answer is peace through strength as this is the only situation the Russians understand.

Doomsday experts know nothing about military strategy and some of their advice, especially the "freeze movement," is wrong.

The United States had been superior in nuclear armament in the 1950s and 1960s, and there was no invasion or bullying of the Soviets, so what do they fear now? Replacement of our older missiles with the cruise missile or MX is not increasing our superiority. We are replacing obsolescence and counteracting the Russian SS-20 missiles in place for years in spite of Salt Talks.

The United States actually has been in a freeze mode for the past 20 years, and the Soviets still continue modernizing and adding to their missiles. What is the use of our continuing the freeze? The more behind we are, the greater the chance for a mistake on the Soviet's part to think they may win (after all look how many millions they have killed during and after the Communist Revolution).

The great majority of concerned persons are well-intentioned patriotic citizens who want to "do something." To be opposed to nuclear war is like being opposed to crime or cancer; everybody is, but very few know how to go about it. These people "feel good" to "do something" to stop nuclear war. Instead, they are inviting hostilities to arise from existing and potential situations of tensions around the world. There is a national divisiveness in which political partisanship and ambition will be mixed with religious conviction and misguided idealism.

At the same time, however, it should be clearly understood that many of the activists in the new "freeze" organizations are professional leftists with backgrounds of prior work in antidefense causes.

If nuclear holocaust prevention activism for the sake of children, society, and the world really is intended instead of antidefense, then please picket the Russians in every country and try to get the message into the Soviet Union. Do not give the impression that the United States is the monster and against peace.

(signed) A.D. Kovacs, M.D.

National Multicenter Stroke Prevention Study

Sept. 6, 1983

Dear Dr. Krosnick:

We are participating in a national multicenter stroke prevention study comparing the long-term effect of a new drug, ticlopidine hydrochloride, to acetylsalicylic acid in reducing the incidence of transient ischemic attacks, stroke, and death. Patients eligible for the study have had TIAs, resolving ischemic neurologic deficits (RINDs), minor strokes, or amaurosis fugax within a three-month period prior to entering the study.

The search for an ideal drug to prevent stroke after a transient cerebral ischemic attack (TIA) has gone on for many years. The Canadian study revealed that acetylsalicylic acid reduced the incidence of stroke in males by 50 percent. As a result the FDA recommended treatment of males after TIA with 325 mg of acetylsalicylic acid four times daily. At institutions with outstanding surgeons, surgery also has been employed successfully to prevent stroke; however, in most series only 30 to 40 percent of patients with typical TIAs are found to be appropriate and eligible for surgery.

Therefore, the search has gone on for the ideal medication which would prevent stroke in a larger proportion of males at-risk and in a significant proportion of at-risk females. The ideal medication also should lack the prominent side effects of acetylsalicylic acid, particularly those of gastric irritation, and interference with prostacyclin (PGI) production.

A promising new drug, ticlopidine hydrochloride, which acts in a unique way on the platelet membrane to inhibit primary wave platelet aggregation to ADP ex vivo, and platelet aggregation after epinephrine collagen, and thrombin challenges, now has been made available to us in patients at risk, in concert with 48 other medical centers and medical practice groups in the United States and Canada. Ticlopidine, in contrast to acetylsalicylic acid, is not a nonsteroidal antiinflammatory drug. It does not alter physiologically valuable gastric and endothelial cell prostaglandin production. It already has found wide use in Europe, over 1,700,000 patient months of exposure, in special specific risk categories such as patients undergoing chronic dialysis where maintenance of shunt patency and prevention of undue platelet loss within the dialysis machine has been demonstrated. It is very well tolerated at the proposed dose level of 250 mg twice daily.

Three thousand patients gathered from the participating clinical groups will be required to demonstrate significant stroke prevention in both males and females who have suffered a recent TIA or minor stroke with minimal residual dysfunction. Ticlopidine only will be dispensed by the participating groups within the context of a double-blind clinical trial. Primary care of the patient remains under the close supervision of the primary physician. Our role is to evaluate periodically the patient from a neurological standpoint and to monitor any possible side effects from the study medication.

There is no charge for participation in the study or for the routine laboratory work performed to monitor the medication. Thus far, nationwide enrollment is over 800 patients.

If you have any questions or desire further information, please contact us at (201) 489-7733 or (201) 489-3346.

Damon M. Fellman, M.D.
Harold H. Goldberg, M.D.
June G. Brubaker, R.N.

CME CALENDAR

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Jan.

17 Postoperative Effects of Anesthetic Agents
7:45-8:45 p.m.—Ramada Inn, Clark
(NJ State Society of Anesthesiologists and AMNJ)

CARDIOLOGY

Dec.

7 Coronary Artery Disease
1:30 p.m.—Essex County Hospital Center, Cedar Grove
(AMNJ)

MEDICINE

Dec.

1 Medical Management of Peptic Ulcer Disease

8 Immune Reconstitution
11 a.m.-12:30 p.m.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

1 Prescribing for the Elderly

8 Special Medical Update: Heart Attack-Beta-Blocker Trial Studies
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

2 Renal Conferences in Nephrology

16 4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMNJ)

6 Management of Hepatitis

20 Cardiology-Clinical Arrhythmias
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

7 Fluid and Electrolyte Imbalance
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

7 Medical Grand Rounds
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

7 Loopholes in Management of Serious Infection
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

7 Update on the Treatment of Paget's Disease for the Primary Physician
9-10 p.m.—Alexian Brothers Hospital, Elizabeth
(Alexian Brothers Hospital and AMNJ)

7 Endocrine Conferences

14 3:30-5 p.m.—Rotates between Newark

21 Beth Israel Medical Center, University

28 Hospital, Newark, VA Medical Center, East Orange, and United Hospitals Medical Center, Newark
(Endocrinology Section, AMNJ)

8 Medical Grand Rounds
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section, AMNJ)

8 Aches and Pains in Children
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

9 Medical Grand Rounds
11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section, AMNJ)

14 Diagnosis and Management of Problems Due to Bleeding and Clotting Defects
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

14 Step Therapy for Angina Pectoris
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

14 Congenital Pulmonary Anomalies
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

16 AIDS
12 noon—Freehold Area Hospital
(AMNJ)

20 Sleep Apnea
12 noon—St. Mary's Hospital, Orange
(AMNJ)

21 Invasive Hemodynamic Monitoring
10:30 a.m.—South Bergen Hospital, Hasbrouck Heights
(AMNJ)

21 Medical Uses of Angioplasty
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

21 AIDS and Other Infections
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

Jan.

4 Nonoperative Management of Chronic Back Pain
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

4 Medical Grand Rounds
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

4 Application of Beta-Blocking Drugs and Calcium Inhibitors to Treatment of Angina, Hypertension, and Arrhythmia

11 Evaluation and Management of Chronic Liver Disease

25 Arthritis-Differential Diagnosis and Modern Treatment
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

4 Endocrine Conferences

11 3:30-5 p.m.—Rotates between Newark

18 Beth Israel Medical Center, University

25 Hospital, and United Hospitals Medical Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

5 Children with Leukemia
9 a.m.—Freehold Area Hospital
(AMNJ)

5 Medical Grand Rounds
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section, AMNJ)

6 Medical Grand Rounds
11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section, AMNJ)

6 Renal Conferences in Nephrology

20 4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMNJ)

10 Newer Cardiac Drugs

24 Emergency Care-Cardiac/Drug Overdose
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

11 Glycosylated Hemoglobin and Home Glucose Monitoring
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

12 Allergy, Current Status
2 p.m.—John E. Runnells Hospital of Union County
(AMNJ)

18 Congestive Heart Failure
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

18 Controversies in Medicine-Geriatrics
1 p.m.—Medical Society of New Jersey, Lawrenceville
(AMNJ)

18 Dermatological Conference
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

19 Newer Antibiotics-Rationale for Selection
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

20 Regional Hospital Case Presentations
8-10 p.m.—St. Barnabas Medical Center, Livingston
(NJ Gastroenterological Society and AMNJ)

25 Clinical Manifestation of Autoimmune Disease

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Waterbury Hospital, Waterbury, Conn.
Associate Clinical Professor
Pulmonary Medicine
Yale University School of Medicine

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Associate Clinical Professor
of Medicine (Oncology)
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CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

WEDNESDAY, DECEMBER 7, 1983

ACUTE MYOCARDIAL INFARCTION

MODERATOR: BERNARD L. SEGAL, M.D.

3:00 CASE PRESENTATION *Stuart Snyder, M.D.*
3:30 COMPARATIVE ROLES OF HEMODYNAMIC, SCINTIGRAPHIC, AND ECHOCARDIOGRAPHIC TECHNIQUES IN ASSESSING PATIENTS WITH ACUTE MYOCARDIAL INFARCTION *Abdulmassih S. Iskandrian, M.D.*
4:00 THROMBOLYTIC THERAPY FOR ACUTE MYOCARDIAL INFARCTION *Charles E. Bemis, M.D.*
4:30 THE ROLE OF ELECTROPHYSIOLOGIC TESTING IN POST-MYOCARDIAL INFARCTION *Charles R. Webb, M.D.*
5:00 THE APPROACH TO THE PATIENT WHO HAS SURVIVED A MYOCARDIAL INFARCTION *Bernard L. Segal, M.D.*
5:30 PANEL DISCUSSION

LECTURE HALL "A"—2nd floor New College Building, Hahnemann University
15th and Vine Streets, Philadelphia, PA
• NO REGISTRATION FEE • NO ADVANCE REGISTRATION REQUIRED •
• CME CATEGORY I CREDITS CERTIFIED •
WINE & CHEESE SERVED FOLLOWING CONFERENCE

10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

NEUROLOGY/PSYCHIATRY

Dec.

5 Lecture Series
8:15 p.m.-10:30 p.m.—192 Chittenden Rd., Clifton
(Essex Psychiatric Seminar and AMNJ)

6 Neuroepilepsy
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

7 Memory Loss, Confusion, and Dementia in an Office Practice
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

13 Psychopharmacology
12 noon—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

19 Principles of Child Psychotherapy
8:30-10:30 p.m.—301 Broad Ave. Englewood
(NJ Psychoanalytic Society and AMNJ)

20 CDS Prescribing Practices-Legal/Illegal
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(AMNJ)

Jan.

9 Can't Go Home at 36
8:15-10:30 p.m.—111 Ridgewood Ave., Glen Ridge
(Essex Psychiatric Seminar and AMNJ)

10 Psychopharmacology
3 p.m.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

16 Principles of Child Psychotherapy
8:30-10:30 p.m.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

18 Mind Bending By Drugs, Intentional and Accidental
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

26 Hypnosis in Medical Practice
12 noon—J.F. Kennedy Medical Center, Edison
(AMNJ)

PATHOLOGY

Dec.

1 Protooncogenes: Mechanisms of Activation

8 Transfection and Human Oncogenes

15 Viruses Associated with Human Cancer
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

14 Pathology Grand Rounds
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

21 Slide Seminar/New Procedure Update
7-9 p.m.—Hyatt House, Cherry Hill
(South Jersey Pathology Society and AMNJ)

Jan.

5 Chemical Carcinogenesis

12 Tumor Promotion

19 Chemical Carcinogenesis Evaluation Systems—In Vitro/In View

26 Radiation Carcinogenesis
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

11 Pathology Grand Rounds
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

PEDIATRICS

Jan.

5 Children with Leukemia
9 a.m.—Freehold Area Hospital
(AMNJ)

RADIOLOGY

Dec.

8 Fundamental Principles of Doppler Ultrasound
7:30-10 p.m.—UMDNJ-Rutgers Medical School, Piscataway
(NJ Institute of Ultrasound in Medicine and AMNJ)

15 Radiology Meeting
7:30-10 p.m.—St. Barnabas Medical Center, Livingston
(Radiological Society of NJ, Radiology Section, and AMNJ)

Jan.

16 Ultrasound
12:30 p.m.—Columbus Hospital
(AMNJ)

18 Dinner Meeting
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

20 Radiology Meeting
7:30-10 p.m.—St. Barnabas Medical Center, Livingston
(Radiological Society of NJ and Radiology Section, AMNJ)

SURGERY

Dec.

7 Surgical Departmental Conference

14 8:30-10 a.m.—Rutgers Medical School Medical Education Bldg., New Brunswick
(UMDNJ, Dept. of Surgery)

19 Anaerobic Infections in Surgery
7:45-9 a.m.—Newark Beth Israel Medical Center
(Searle Pharmaceuticals, Inc. and AMNJ)

21 Update on the Management of Surgical Infections
1-2 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

Jan.

4 Surgical Departmental Conferences

11 8:30-10 a.m.—Rutgers Medical School,

18 New Brunswick

25 *(UMDNJ)*

SURGICAL SPECIALTIES

Dec.

1 Vascular Surgical Rounds

8 4-5 p.m.—Rutgers Medical School

15 Medical Education Bldg., New

22 Brunswick

29 *(UMDNJ)*

14 Examination of Compensable Injuries
7:15 a.m.—Point Pleasant Hospital
(Point Pleasant Hospital)

20 Cancer Surgery of the Breast
8:30-9:30 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

Jan.

3 Lung Cancer
7:30 p.m.—Burdette Tomlin Memorial Hospital, Cape May Court House
(AMNJ)

5 Vascular Surgical Rounds

12 4-5 p.m.—Rutgers Medical School,

19 New Brunswick

26 *(UMDNJ)*

18 GI Surgery for Ulcer
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

24 Intracranial Bypass Surgery
7:30-8:30 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

MISCELLANEOUS

Dec.

1 Learning, Speech, and Language Disorders
9 a.m.—Freehold Area Hospital
(AMNJ)

17 The Problem of the Impaired Physician
12 noon—St. Mary's Hospital, Orange
(AMNJ)

OBITUARIES

Dr. Fritz F. Adler

Fritz Frederick Adler, M.D., former president of Fair Lawn Memorial Hospital, died on July 29, 1983. Dr. Adler was born in 1910 and earned a medical degree at the University of Vienna, Austria, in 1937. He was a family practitioner in Paterson since 1946 and was a member of our Passaic County component and of the American Medical Association.

Dr. Ralph J. Belford

Ralph Jones Belford, M.D., died at the age of 84 on August 16, 1983. A former chief surgeon at The Medical Center at Princeton, Dr. Belford died at his home after a long illness. Dr. Belford earned his medical degree at Johns Hopkins Medical School, Maryland, in 1923. He was a member of our Mercer County component and of the American Medical Association, a Diplomate of the American Board of Surgery, and a Fellow of the American College of Surgeons. The medical library at The Medical Center at Princeton is named in honor of Dr. Belford, as is the award given to the outstanding employee of the year at the Medical Center.

Dr. Le Roy Curtis

A member of our Passaic County component, Le Roy Curtis died on June 4, 1983. Born in 1920, Dr. Curtis received his medical degree from New York Medical College in 1950. A family practitioner, Dr. Curtis was affiliated with Greater Paterson General Hospital, Wayne.

Dr. Richard Gilligan

A member of our Bergen County component, Richard Patrick Gilligan, M.D., died on August 18, 1983. Born in 1927, Dr. Gilligan earned his medical degree at Georgetown University Medical College, Washington, D.C., in 1954. Dr. Gilligan was a staff physician at St. Mary Hospital, Hoboken, for 25 years. Dr. Gilligan was a Diplomate of the American Board of Internal Medicine and a member of the American Medical Association.

Dr. Thomas F. Hunt

At the age of 76, Thomas Francis Hunt, M.D., died on July 21, 1983. Dr. Hunt earned his medical degree at Georgetown Medical School, Washington, in 1933 and returned to his hometown of Elizabeth to practice. He served the local community until his retirement in 1982 and was affiliated with St. Elizabeth's Hospital and Alexian Brothers Hospital, both in Elizabeth. Dr. Hunt was a member of our Union County component and of the American Medical Association. Dr. Hunt received MSNJ's Golden Merit Award last year.

Dr. William Kruger

At the age of 86, William Kruger, M.D., died on August 7, 1983. Dr. Kruger earned his medical degree at the University of Michigan Medical School in 1923 and served his internship at Newark Beth Israel Medical Center. He served on the orthopedic staffs of Saint James Hospital, Newark Beth Israel Medical Center, and Newark City Hospital, all in Newark. Dr. Kruger received MSNJ's Golden Merit Award in 1973 for 50 years of service to his community. A past president of the New Jersey Orthopaedic Society, Dr. Kruger was a member of our Essex County component and of the American Medical Association, a Fellow of the American College of Surgeons, and a Diplomate of the American Board of Orthopedic Surgery.

Dr. Raymond H. Mathews

At the grand age of 95, Raymond Hamilton Mathews, M.D., died on July 24, 1983. Dr. Mathews received his medical degree from Columbia University College of Physicians and Surgeons in 1915. He served on the staff of Memorial Hospital, Morristown. A retired member of our Morris County component, Dr. Mathews was a member of the American Medical Association, a Diplomate of the American Board of Otolaryngology, and a Fellow of the American College of Surgeons. Dr. Mathews was awarded MSNJ's Golden Merit Award for his service as a physician in 1965.

Dr. Irving A. Silverman

At the grand age of 89, Irving Alexander Silverman, M.D., died on July 12, 1983. Dr. Silverman earned his medical degree in 1926 from University of Tennessee College of Medicine. Until his retirement, Dr. Silverman was affiliated with Beth Israel Medical Center, Passaic, and Barnert Memorial Hospital Center, Paterson. Dr. Silverman was a retired member of our Passaic County component and a member of the American Medical Association. In 1976, Dr. Silverman was a recipient of MSNJ's Golden Merit Award, marking his 50 years of service as a physician.

Dr. Louis E. Toub

Louis Edward Toub, M.D., a member of our Burlington County component, died on August 16, 1983. Born in 1927, Dr. Toub received his medical degree from Hahnemann Medical College, Pennsylvania, in 1954. During his career, Dr. Toub was affiliated with the urology departments at Rancocas Valley Hospital, Willingboro, and St. Luke Hospital, Philadelphia.

BOOK REVIEWS

Atlas of Standard Surgical Procedures

William V. McDermott, Jr., M.D. Philadelphia, PA, Lea & Febiger, 1983. Pp. 193. ($47.50)

This new atlas, designed specifically for a general surgeon in residency training, comes from a prestigious medical school and residency training program.

The book opens with a discussion of incisions, principles of drainage, and anastomoses. Following this is a series of nine additional chapters discussing surgery in areas of vascular, transplantation, and oncologic subspecialties as well as in endocrine, gastrointestinal, colorectal, pancreatobiliary, and hepatic surgery. Chapters on lymph node dissections and surgery of the breast are included as well. It is understandable that many limitations arbitrarily have been imposed, e.g. stapling techniques and the alterations and variations of many procedures.

Atlas of Standard Surgical Procedures is a practical and authoritative atlas that spans a series of subspecialties in general surgery. The book's concise format makes it an excellent reference for any general surgeon who wishes to review a procedure. This text will prove to be an excellent atlas for residents, directors of surgical training programs, and surgical faculty involved in training residents and students.

Stanley S. Fieber, M.D.

Bulimia: The Binge-Purge Compulsion

Janice M. Cauwels. New York, NY, Doubleday & Company, 1983. Pp. 249. ($14.95)

This is a readable book on bulimia and associated eating problems by a professional medical writer who interviewed a number of bulimics and professionals. The book is intended to inform professionals and nonprofessionals about the nature of bulimia. The professional reader will find the book interesting when it is written from the patient's point of view. There is a good collection of anecdotal reports from present and former bulimics, though the sampling is biased. The theme that runs through these reports is, "I wish someone had confronted me about my eating problem"; however, the theme does not seem to be as universal as the author suggests.

The professional will find the discussion of the similarities and differences between bulimia, anorexia nervosa, and other eating disorders of interest, as well as the suggested possible relationship between bulimic behavior and alcoholism and other forms of physiological and habit dependencies. However, the professional reader will want more research studies to justify the arguments made.

Cauwels suggests that binge eating and binge vomiting are psychiatric problems; however, these problems are quite frequent among college-age females who seem to outgrow the disturbance. Also, many athletes carry out this type of behavior to maintain their weight classification.

The recommended form of treatment is seen as multidisciplinary and highly individualized including family therapy, behavior therapy, nutritional counseling, and medication.

One feature of the book is its inclusion of organizations throughout the United States to which the sufferer can write for specific information.

The book is good reading for those potential or actual bulimia or anorexia sufferers and their families. The book gives hope to the sufferer.

The professional may wish to assign this book as homework to the bulimic or her family.

John M. Atthowe, Jr., Ph.D.
UMDNJ—Rutgers Medical School

Drugs in Pregnancy and Lactation

Gerald G. Briggs, et al. Baltimore, MD, Williams and Wilkins Company, 1983. Pp. 415. ($39.95)

Two pharmacologists and two physicians have collaborated in the presentation of this thorough reference guide to fetal and neonatal risk factors inherent in practically every medication or drug available. Although the drugs are listed in the text alphabetically by their generic names with their accompanying monographs, their more recognizable trade names are listed in the index so that the reader quickly can locate the particular drug that might be prescribed or taken inadvertently by a pregnant and/or lactating woman.

This book answers or seems to answer a current and practical need of the clinician who provides medical, dental, or obstetrical care; however, the monographs accompanying each drug frequently fail to provide the specific answers and clear-cut explanations being sought. This obvious fault probably is unavoidable since the authors are obliged to employ the risk factors, A, B, C, D, and X, that have been devised by the Food and Drug Administration whose circumlocution offers ultrascientific truth cloaked in legal jargon. In categories A and B are drugs which have not demonstrated a risk in pregnancy or lactation for all practical purposes while drugs in category X are at the opposite end of the spectrum. The monographs for drugs in risk categories C and D which comprise the majority of drugs in everyday clinical use frequently tend to confuse rather than clarify the situation. Despite this apparent problem, every clinician who treats a pregnant or lactating patient will find that this reference guide will make it easier to select a drug with the least risk.

Jerome Abrams, M.D.

Handbook of Pediatrics

Henry K. Silver, C. Henry Kempe, Henry B. Bruyn. Los Altos, CA, Lange Medical Publications, 1983. Pp. 883. ($13)

This text does not seem to be of value to the physician trained in disorders of childhood and in child health, but perhaps a student or a physician not used to dealing with children might find the brief summaries in this hand-sized book helpful as a quick reference. There is not room enough for the presentation of balanced judgment, any indication of uncertainty, or specifics of what to search for, risks, prognosis, or detailed methods of management. There is no useful set of references from which one could search out the additional information needed. *Handbook of Pediatrics* cannot be recommended with any confidence for physicians; nurses might find it of value.

Avrum L. Katcher, M.D.

Manual of Pediatric Parenteral Nutrition

John A. Kerner, Jr., (ed). New York, NY, John Wiley & Sons, Inc., 1983. Pp. 365. ($34.95)

Given that it costs about $400 a day to maintain a premature infant on total parenteral nutrition, the price of this excellent paperback from the Stanford University Medical Center may be reasonable. This book is an excellent text on nutrition as well as on parenteral nutrition and I recommend it to all physicians who treat children.

The state of the art is such that total parenteral nutrition is fast becoming complete nutrition. Amino acids are given at 2 to 3 gm/kg/day. Lipids at 0.5 to 4 gm/kg/day with glucose as tolerated and water as needed. Cations given include sodium, potassium, magnesium, zinc, iron, copper, manganese, chromium, and selenium. Anions given include phosphate, fluoride, iodide, and acetate. Also given are four fat-soluble vitamins and nine water-soluble vitamins. The results can be fantastic especially if one is aware of the many possible complications which are well discussed in one of the best sections of this manual.

Crystalline L-amino acid mixtures are preferred over the originally used protein hydrolysates. Glucose is considered better than fructose, galactose, sorbitol, or glycerol. There are excellent discussions of some currently unresolved problems including the need for carnitine, cysteine, taurine, and molybdenum.

In this manual there is a computer program for use in preparing TPN solutions, especially handy for those who understand computer programs. There are excellent discussions of TPN at home as well as the use of partial parenteral nutrition and partial enteral nutrition. The use of central veins and peripheral veins also is well discussed.

Helfrick and Abelson reported the first successful use of total parenteral nutrition in an infant in 1944. Progress in this field has been one of the major medical achievements of this century.

Solomon J. Cohen, M.D.

Pediatric Ophthalmology, Volumes 1 and 2

Robison D. Harley, M.D., (ed). Philadelphia, PA, W.B. Saunders Company, 1983. Pp. 1402.

This two-volume set is a comprehensive review of the entire ophthalmology field. *Pediatric Ophthalmology* goes beyond the problems of children; its extensive scope makes the book an excellent reference. Part of the strength of these books is derived from the expertise of 59 contributors. The result is a consistently high level of authority on particular subjects. The problems of diagnosis and therapy of various diseases are well handled. As expected in a book on pediatric ophthalmology, congenital defects and genetically determined hereditary, metabolic, and degenerative processes have a special prominence.

In the first volume, subjects such as neonatology, ophthalmology, genetics, pharmacology, methods of examination, ultrasonography, electrodiagnostic testing, strabismus, anterior segment ischemia, refraction, amblyopia, orbital, lacrimal, lens, vitreous, retinal problems, and fluorescein angiography are covered.

The second volume considers pediatric neuro-ophthalmology, systemic disorders, allergic reactions and other hypersensitivity immunopathies, inborn errors of metabolism, tumors, and subnormal vision.

Both volumes rely heavily on illustrations; many are in color. The quality is high in clarity and accuracy, and the illustrations help significantly in diagnosis of the numerous manifestations of ocular and systemic diseases. Tables also enhance the book's usefulness; they provide concise resumes of the subject under consideration. The same sense of completeness determines the detailed bibliographies. Some chapters even break down the bibliographical entries into useful subtopics.

Anyone who takes care of children will find this two-volume book useful. It is the culminating work of Robison D. Harley, a man who contributed to the development of ophthalmology and the training of its practitioners.

Alfonse A. Cinotti, M.D.

Practical Cardiology

William J. French, M.D., and J. Michael Criley, M.D., (eds). New York, NY, John Wiley & Sons, Inc., 1983. Pp. 302. ($19.95)

This excellent, concise monograph is a compilation of material derived from a continuing course sponsored by the UCLA School of Medicine. Though it suffers from the usual problems of multiauthored texts, such as overlapping, contradictions, and repetition, it achieves its goal of updating ischemic and valvular heart disease for the primary care physician.

The initial chapter, an overview of ischemic heart disease, is honest and concise, but fails to mention important contributions such as the role of electrophysiologic study in sudden death survivors and that of calcium-blocking agents in angina pectoris. Chapters Two and Three are excellent reviews of the clinical and laboratory evaluation of patients with suspected ischemic heart disease. Especially noteworthy are Figure one (page 25), "Diagnostic evaluation of chest pain," and Figure one (page 28), "Stepwise approach to basic evaluation, noninvasive and invasive procedures." Chapters Four through Six deal with various aspects of angina; they should be replaced by a single, comprehensive review that would avoid the pitfalls of overlapping, omissions, and inconsistencies. The section, "Management of Common Cardiac Arrhythmias," deals only with life-threatening ventricular arrhythmias!

Part I, "Ischemic Heart Disease" concludes with sketchy but reasonably good chapters on rehabilitation and surgery.

Part II, "Valvular Heart Disease" is a gem! Chapter 12, "The Physiologic Approach to Bedside Diagnosis," has two superb tables outlining the clinical findings in the major valvular lesions and their "simulators." In addition, the graphical figures are clear, high-quality reproductions. "The Chest X-Ray in Valvular Heart Disease" is the highlight of the text. The tables, line drawings, and actual films are splendid. "Echocardiography in Valvular Heart Disease" proved unexciting because the chapter was limited to classical, worn-out M-mode presentations with very little on two-dimensional and other, newer formats. The monograph concludes with a lucid presentation of indications for catheterization and surgery nicely illustrated by a number of stepwise diagrams designed to guide the non-cardiologist, primary physician.

I enjoyed reading this book, and I recommend it to cardiac nurse specialists, house officers, generalists, and internists.

Edwin L. Rothfeld, M.D.

Recovery. Stories of Alcoholism and Survival

Amy Stromsten. New Brunswick, NJ Rutgers Center of Alcohol Studies, 1983 Pp. 143. ($20)

This is an interesting collection o vignettes from the lives of people fron all walks of life who have had problems

with the abuse of alcohol.

Several issues clearly emerge from the collected stories—"loss of control" of alcohol intake is the common denominator; active participation in Alcoholics Anonymous seems the most successful therapy; and not everyone accepts their illness or succeeds in recovery.

It seems to me that the ideal use of this book would be in the practice of physicians who confront and treat patients with alcohol problems. Reading through these case histories may enable the patients to identify more clearly the existence of their own disease.

David I. Canavan, M.D.
Medical Director
Impaired Physicians Program

Review of Medical Physiology, 11th Edition

W. F. Ganong, M.D. Los Altos, CA, Lange Medical Publications, 1983. Pp. 643. ($20)

Dr. Ganong has managed to present a remarkable amount of information in this volume, which also has been translated into a dozen foreign languages. Starting with basic cellular physiology, the book then is divided into functional areas, including nerve and muscle cells, endocrinology and metabolism, gastrointestinal, respiration, and formation and excretion of urine.

The clinician will find concise discussions of such relevant subjects as cell membrane resting potentials, sodium and potassium interrelationships, muscle contraction, nerve cell receptors, sensory physiology, sleep, and motor pathways. Diseases which may be due to physiologic dysfunction are illustrated appropriately.

The endocrine system, including energy, metabolism and nutrition, thyroid physiology, adrenal physiology, pituitary, and sex hormones, especially is interesting, and contains new information and physiologic considerations.

Gastrointestinal physiology, the immune system, and the cardiovascular system are well presented, and the sections on respiration, renal function, and extracellular fluids are concise and valuable.

Most chapters contain up-to-date bibliographies with references to current literature for those seeking further information.

Those wishing to have a ready reference to a concise summary of human physiology will find this book a useful addition to their libraries.

Joseph Peyser, M.D.

Treatment of Mental Disorders

John H. Greist, James W. Jefferson, Robert L. Spitzer (eds). New York, NY, Oxford University Press, 1982. Pp. 548. ($21.95)

Medical psychiatry is in full bloom, to which this book attests. The organization of this text follows the *Diagnostics and Statistical Manual of Mental Disorders, Third Edition (DSM III),* the latest effort of the American Psychiatric Association to formulate distinct disease entities. Thus, the book is a companion to *DSM III.*

Although multiauthored, the book remarkably is homogeneous, which speaks well for the work of the editors. All authors drew their conclusions from controlled, randomized, double-blind clinical investigations that are well documented in a bibliography at the end of each chapter. At times, however, I also wished to learn from the authors' personal experience.

The emphasis on controlled clinical investigation, of course, favors those treatment modalities which can be tested and validated in this manner, i.e. psychopharmacotherapy and behavior modification, supportive psychotherapy, and the sociotherapies. Therefore, the book deals mostly with these forms of treatment and not with psychoanalytic psychotherapy, for which controlled outcome studies are not yet and never may be feasible. Excluding psychoanalytic psychotherapy, then, the book represents a comprehensive, up-to-date, reliable guide to the treatment of mental disorders.

The reader should not turn to this book for an indepth understanding of the biochemical or psychodynamic roots of treatment. Wisely, the authors considered this beyond the scope of their work. In the next edition, however, I would like to see a more inclusive presentation of psychotropic medications.

This book is just as valuable to the neurologist, the internist, and the family physician as it is to the general psychiatrist. For a year or so it will be within easy reach in my library, next to the *DSM III.*

A. Johan Noordsij, M.D.

Virus Infections of the Gastrointestinal Tract

David A.J. Tyrrell and Albert Z. Kapikian (eds). New York, NY, Marcel Dekker, Inc., 1982. Pp. 490. ($59.50)

Viral diarrhea remains the number one killer of children under two years of age throughout the world with 10 million deaths per year. Tyrrell and Kapikian, truly the most innovative physicians doing research in the field, have published a superb book on the virus of the intestinal tract. Designed for specialist and nonspecialist alike, the authors have put together their knowledge in concise and lucid prose. Using a superb technique of direct electron microscopy, these authors demonstrated the major role of the rotavirus in 1973. With a splendid group of contributors including such world-renowned people as Ian Holmes, M.B. Pepys, and Neil Blacklow, such topics as classification of viruses, enzyme immunoassays, immunology, clinical features of the Norwalk agent, coronaviruses, and comparative animal viruses of the intestinal tract are discussed in various chapters. The quality of the print, charts, and photographs are outstanding.

I do not believe that there is much practical interest to the typical American physician; to me, this is a magnificent book on the masterful way man conquers huge problems and historically the story of viral diarrhea in infancy.

A superb book for every medical library and infectious disease specialist, and a fine gift for a medical student interested in research.

Leon G. Smith, M.D.

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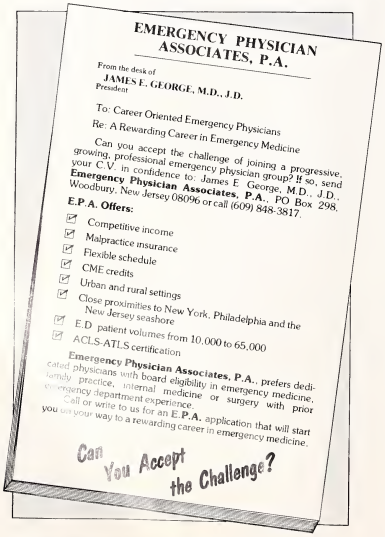
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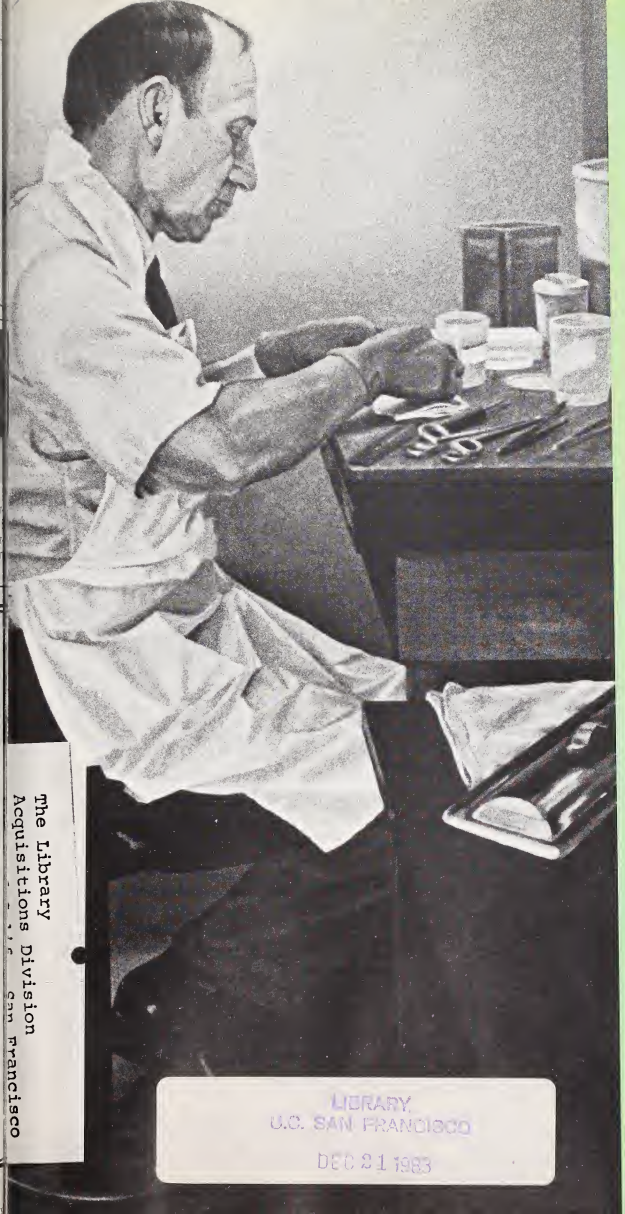
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R.L. Siegel, M.D.

Amyloidosis
N.P. Zauber, M.D.
M.H. Wallen, M.D.

Physician Legal Bulletin
James E. George, M.D., J.D.
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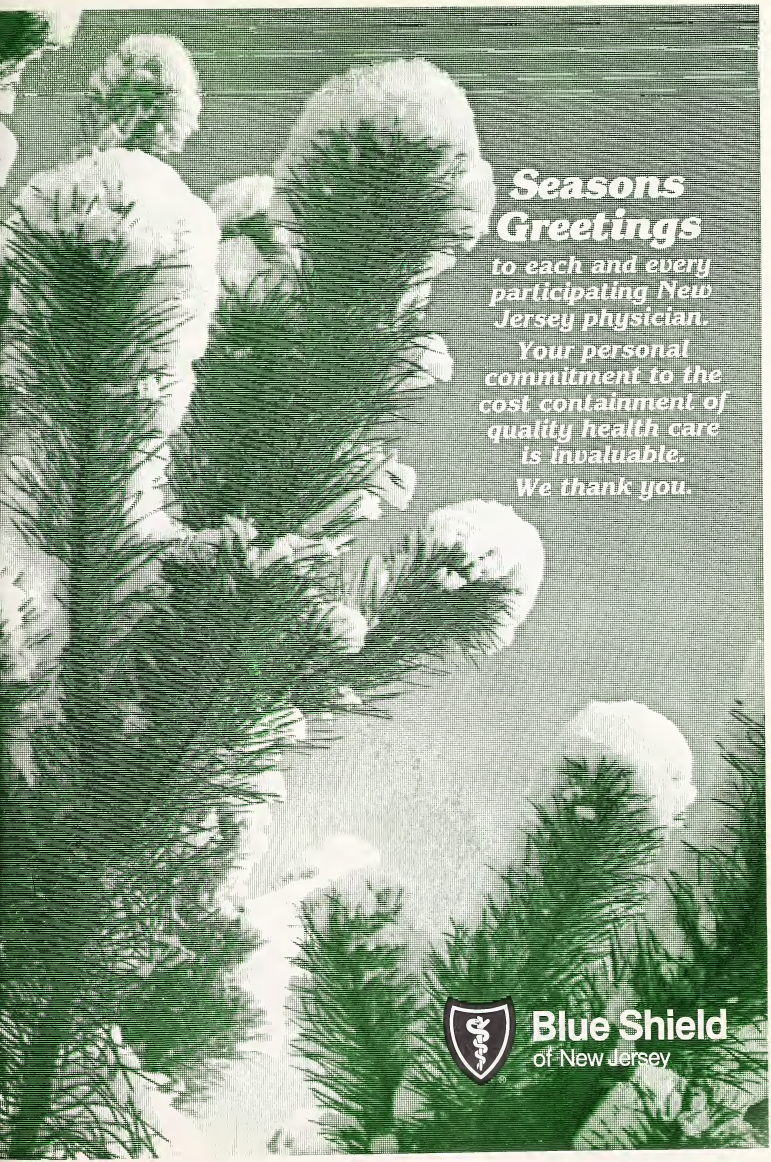
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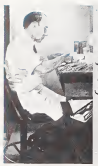
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On The Cover: The cover illustration is a section of an oil painting by Constance Bottinelli, communicating a life dedicated to medicine. The painting was commissioned by Burlington County Memorial Hospital, Mount Holly, and funded by the New Jersey State Council on the Arts. Read the story on page 995.

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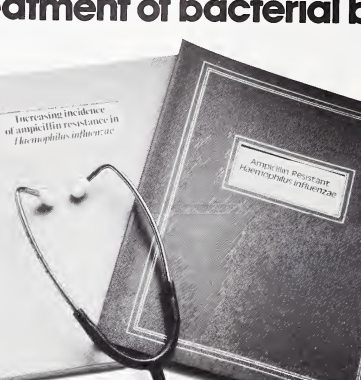
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Lower respiratory tract infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PENICILLIN-INDUCED REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibacterial agents (including macrolides, penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Mild cases with bronch-pesticum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by clostridia is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuation alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, consideration should be given to the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: General Precautions—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed, the presence of a positive Coombs' test may be due to the drug. Hemolytic reactions have been reported in patients given cephalosporin antibiotics before methicillin, and the possibility should be considered that a positive Coombs' test may be due to this drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such circumstances, careful clinical observation and laboratory studies should be made because adjustment may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions, but not with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strips, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and a teratogenic effect does not appear to be present. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.76, 2.33, and 3.18 mcg/ml at 1, 2, and 3 hours, respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor in clinical trials are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 75).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include eosinophilia (1 in 100), pruritus, urticaria, and positive Coombs' tests each occurring in less than 1 in 200 patients. Cases of serum sickness-like reactions, erythema multiforme or other skin disinterdations characterized by arthritis-arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after discontinuation. Other hypersensitivity reactions have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported; half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Clinical-Laboratory Findings—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain clinical significance, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematologic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[06578(R)]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See product literature.

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MEMBERSHIP NEWSLETTER

MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 5

THE DRG SWEEP

On October 1, 1983, DRGs (Diagnosis Related Groups) became the method of reimbursement for the payment of hospital services under the Medicare program. The entire nation now is swept into the game although it must be noted that we all are playing by different rules.

Meanwhile, in New Jersey, there is no creditable evidence that the DRG method of payment has produced a lower cost to the patient; in a number of instances it has produced a greater return to the hospital. However, there is a factor which points to the serious flaw in using DRGs as the method of payment. The system assumes that patients will fall into neat averages and that the costs of treating those patients can be predicted and averaged. Currently, 35 percent of the cases are "outliers." With that many falling outside the field, it is obvious the program will collapse unless severe adjustments are made promptly.

In Kansas, Blue Cross/Blue Shield have converted to a DRG format. All hospitals in Kansas will be divided into seven peer groups and payments will be based on allowances for 467 DRGs. Contracting hospitals will not bill in excess of the DRG payment. The maximum payment will be the same for all hospitals in the peer group. The prevailing charge program for doctors will be redesigned with new maximum allowances for each service. Blue Cross/Blue Shield of Kansas will set maximums as to how much the allowances may increase in the year ahead.

A system, which originated in New Jersey, was tested but never analyzed, now has become the "state of the art." Since the New Jersey "outlier" frequency is an indicator that the concept lacks medical and mathematical logic, the question now becomes a matter of restoring order after governmentally orchestrated chaos.

CONSOLIDATED STANDARDS MANUAL

The Joint Commission on Accreditation of Hospitals (JCAH) has announced publication of the 1983 edition of the *Consolidated Standards Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities.* The *Consolidated Standards Manual* contains state-of-the-art standards for psychiatric and substance abuse facilities. It is designed to serve as an education and self-assessment tool for staff in these facilities, as well as an accreditation survey instrument. To order the *Consolidated Standards Manual,* send $30 per copy to: Cashier, JCAH, 875 North Michigan Avenue, Chicago, IL 60611. For further information regarding any JCAH publication, telephone the Department of Publications at (312) 642-6061.

PERSONAL CARE SERVICES

The Division of Medical Assistance and Health Services has proposed regulations governing personal care services that appeared in the October 17, 1983, issue of the *New Jersey Register.* Personal care assistant services are health-related tasks performed by a qualified individual in a recipient's home, under the supervision of a registered nurse, as certified by a physician in accordance with a written plan of care and prior authorization by the state agency. Pursuant to federal regulations, personal care services may not be performed by a member of the recipient's family.

The duties and qualifications of personal care assistants are contained in the regulations. Personal care assistant services are limited to a maximum of 20 hours per week at a reimbursement rate up to $7.00 per hour. Up to $25.00 may be billed for an initial nursing evaluation visit.

This is only a brief synopsis of the text of the rule. Please be advised that this proposal will not be considered official Division policy until it formally is adopted.

HEALTH CARE COST CONTROL ACT

The AMA testified in opposition to H.R. 3261, the "Health Care Cost Control Act of 1983," and urged the Committee to reject the bill. The bill, introduced by Representative Shannon (D-MA), would establish caps on increases in revenues for all hospital inpatient services, as well as caps on increases in charges for hospital outpatient services, and for all physician services. The bill should go beyond federal programs, such as Medicare and Medicaid, and would institute controls in the private sector as well. Severe monetary penalties would apply to institutions or individuals who violated provisions of the bill.

The Association pointed out that the bill represents a revised version of the "Hospital Cost-Containment Program," proposed by the Carter Administration in 1977. AMA opposed rigid price and revenue controls on one sector of the economy, pointing out that the rest of the economy would be free of controls. The testimony stressed the fact that the proposed syste would require massive federal bureaucratic admini tration and would interfere with competitive initiative within the private sector. The AMA also opposed th mandated acceptance of Medicare assignment on a claims for Medicare patients. (Testimony to the Sub committee on Health, Committee on Ways an Means, United States House of Representatives, Sep tember 28, 1983.)

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In May 1983, a nationwide cocaine treatment referral and information service was established as a confidential, not-for-profit service by Fair Oaks Hospital Summit. Counselors at the center can refer callers to the nearest treatment center, either an inpatient o outpatient facility. For assistance in treating cocaine abuse, just dial, 800-COCAINE.

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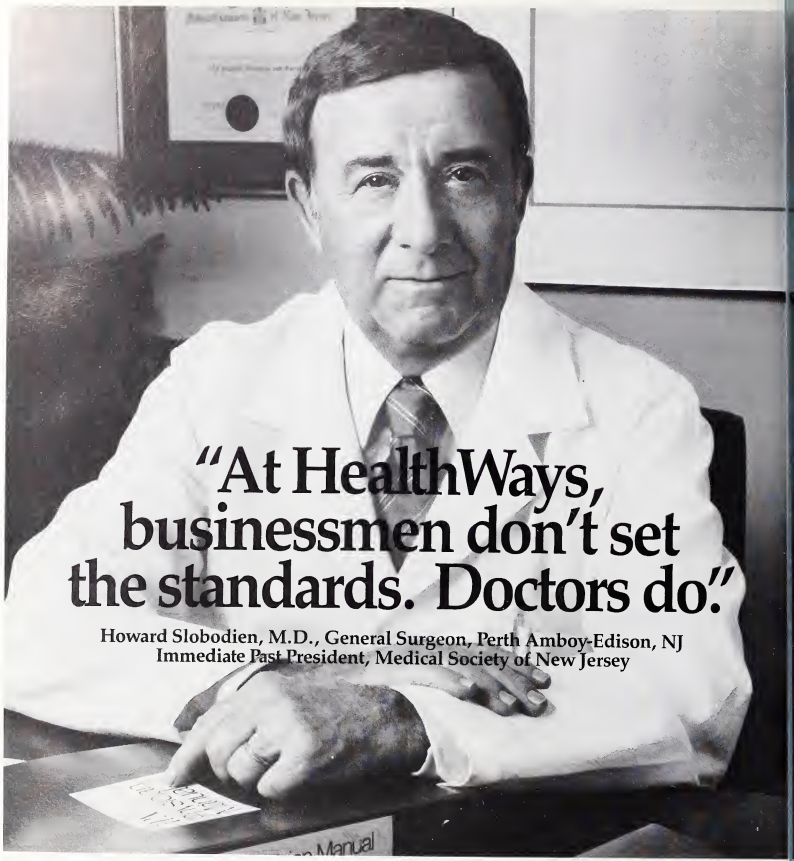
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Pharmaceutical and Medical Advances

Twenty more PMIs now are available from the AMA, bringing the total to 60. For the first time, the AMA issuing Patient Medication Instruction (PMI) sheets for ie over-the-counter (OTC) pharmaceutical products other ian insulin; antihistamines that are used widely in non-rescription preparations for motion sickness, allergies, and somnia; and bronchodilator aerosols that are used in both rescriptions and OTC products for asthma, aspirin, and cetaminophen. Previously, PMIs have been available for rescription drugs only.

Five drugs against hypertension are described in the new MIs. Pads of 100 sheets each may be ordered from the PMI rder Department, AMA, P.O. Box 8052, Rolling leadows, IL 60008. Minimum order is five pads.

The following is a complete list of new PMIs: henothiazines, tricyclic antidepressants, antihistamines, ronchodilator aerosols, oral pentazocine, propoxyphene nd propoxyphene with aspirin or acetaminophen, aspirin, odeine, acetaminophen, amiloride and amiloride with iazide, triamterene and triamterene with thiazide, prazosin, pironolactone and spironolactone with thiazide, clonidine, ethysergide, diphenoxylate with atropine, isotretinoin, otassium supplements, methotrexate (for psoriasis), and teroid antibiotic eyedrops. (*AMA Newsletter,* Vol. 15, No. 3, September 26, 1983.)

ADVANCES IN FETAL THERAPY

As the ability to prevent and correct fetal defects expands, o too does fetal therapy's potential for legal and ethical amifications. Concern for the fetus may well lead to en-roachment upon a mother's rights, because there is no way o act upon the fetus without acting upon the body of the woman.

The courts already have been asked to intervene in several ases: (1) A Maryland physician asked a juvenile court judge o order a pregnant woman to abstain from drugs and submit o urine tests for the duration of her pregnancy. (2) Siding with hospital personnel in two separate cases, juvenile courts n Georgia and Colorado ordered unwilling women to under-go cesarean section and related procedures deemed necessary by the attending physician to sustain the life of the child.

Citing the two cases of coerced cesarean section as precedents for similar actions involving in utero surgical techniques, a University of Texas Law School professor, in the *Journal of Legal Medicine,* maintained that as fetal therapies become established procedures, physicians and parents will be obligated to use them. Although a woman retains the right to abort, should she opt to continue a pregnancy, she will "not be free to have an unhealthy or defective child if a healthy child would otherwise be born," says professor of law, John A. Robertson. In his view, the physician who did not perform an established fetal therapy, or inform parents of its availability elsewhere, would be held liable. Robertson also describes a no-win situation in which the physician who acceded to a mother's refusal to undergo an established fetal therapy could be held criminally liable if the fetus died or were born defective, but if that physician overrode the mother's refusal, he or she could be charged with assault and battery on the woman.

Only if the health risk to the mother were deemed greater than the benefit to the fetus or if one twin would be endangered by therapy of the other would foregoing an established procedure be justified, Robertson says, adding that not many fetal therapies would be considered as entailing a significant maternal risk.

On the other hand, he continues, because the mother would have no legal or moral duty to submit to an experimental or unproved procedure, the physician, in turn, would not be obligated to override her refusal to undergo such a procedure.

Should the woman consent and the outcome be unfavorable, he says, the physician would be liable only if it were shown that he or she lacked the requisite training and skill to have performed the experimental procedure in the first place.

Yale's Dr. Maurice Mahoney, a pioneer in prenatal detection and correction of birth defects, maintains that "when a woman decides she will carry a pregnancy to term, she simultaneously commits herself to look after that baby's welfare," and he believes that society and the legal system are moving toward that view.

If a medical conflict arises between the health of the mother and that of the child, "the mother's health comes first," he says, although "when it's a matter of low risk or inconvenience to the mother, the fetus takes precedence—but a court would have to be asked to decide."

Though all fetal surgery is highly experimental at this time, he adds, it is not premature to start thinking about the conflicts that might arise once these procedures become established. (*Medical World News,* September 12, 1983.)

DID YOU KNOW . . .

More and more hospitals, concerned about their own vulnerability in malpractice suits, may begin dictating how much liability insurance physicians on staff must carry? In Michigan, at least 59 hospitals require a minimum coverage, and more are expected to require it for each attending physician by January 1984. Detroit's Sinai Hospital has revoked

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse who are, respectively, Director of the Department and Director of Special Projects.

privileges of 15 physicians who refused to obtain coverage. Twelve other physicians who sued the hospital and lost, agreed to comply with the requirement. Courts in other states, too, have upheld the legality of requiring malpractice coverage as a condition for staff privileges. (*Medical Economics,* September 5, 1983.)

Twenty physician-owned liability companies increased overall rates during the three billing periods since 1980, according to a poll conducted by the American Medical Assurance Co? Increases ranged from 10 percent to 99 percent on a compounded basis. Half of the 20 responding companies established rate increases in each of the three years, and six raised premiums in two out of the three years. The average increase over the past three years was 47 percent. (*AMA Newsletter,* Vol. 15, No. 31, September 12, 1983.)

The Iowa Supreme Court has upheld a ruling that a group of anesthesiologists had the right to refuse to work with a Cedar Rapids neurosurgeon they felt was incompetent—even though two hospital peer review committees said he was competent? The anesthesiologists, who provided all the anesthesia for the hospitals where the physician had privileges, said they feared a repetition of previous surgical errors that included two cases in which the doctor had opened the wrong side of a patient's skull. The neurosurgeon had charged that the boycott prevented him from practicing. (*Medical Economics,* August 8, 1983.)

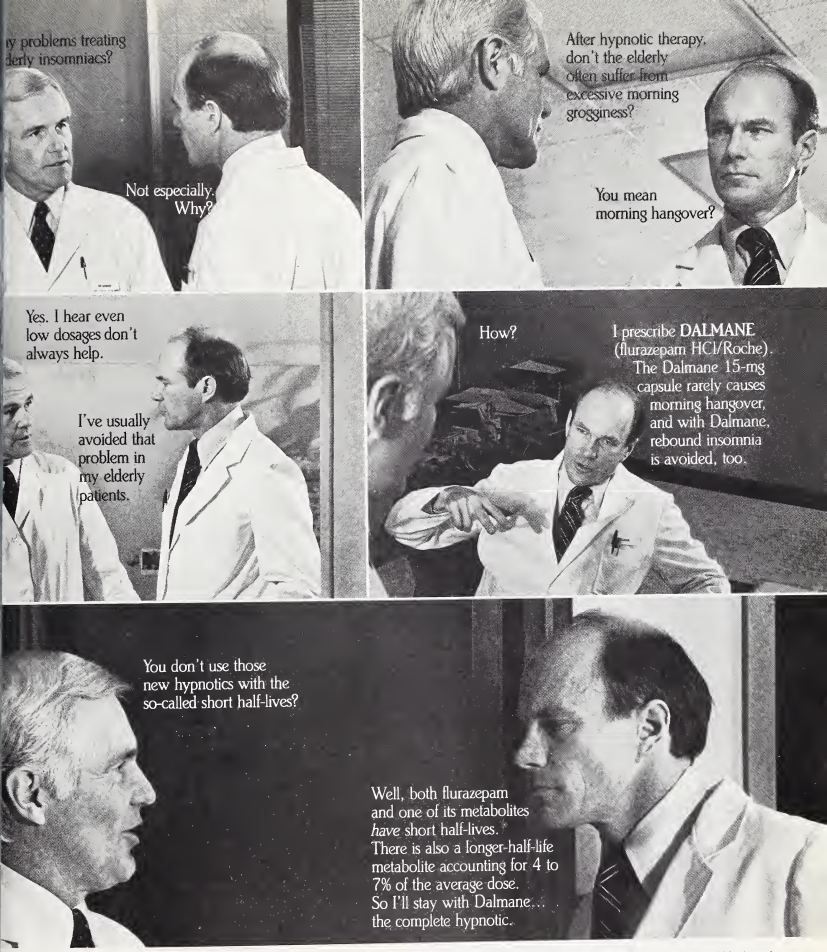
PROPOSED LEGISLATION REGARDING COMPETENCY OF EXPERT WITNESS

A number of states, including New York and Michigan, are proposing legislation regarding medical malpractice which focuses on the role of the expert witness. This ty of proposed legislation is designed to place limits on t competency of expert testimony via the establishment requirements for expert witnesses in cases agair nonspecialists and specialists.

The Michigan State Medical Society is proposing the fc lowing requirements to be considered for enactment: "N person shall be deemed competent to give expert testimo on the liability issues as defined in Michigan Court of A peals 600.2912A:

1. In the case of a claim against a nonspecialist: (a) su person holds a license to practice medicine and surgery osteopathic medicine and surgery granted by the appropria licensing board of the state of Michigan; and (b) such perso devotes at least three-fourths of his or her occupational ar professional time to the active clinical practice of medici and surgery, or osteopathic medicine or surgery, and/or its instruction in an accredited medical or osteopathic schoc

2. In the case of a claim against a specialist: (a) su person holds a current license to practice medicine and su gery or osteopathic medicine and surgery granted by th appropriate licensing board of any state; and (b) such perso was and is recognized as a practitioner in the same specialt as the accused specialist, both at the time of the occurrenc of the alleged claim and at the time of testifying; and (c) suc person devotes at least three-fouths of his or her occupa tional and professional time to the active clinical practice medicine and surgery in the same specialty as the accuse specialist, or osteopathic medicine and surgery in the sam specialty as the accused specialist, and/or to its instructio in an accredited medical or osteopathic school in the sam field as the accused specialist."



Because the risk of oversedation, dizziness and ataxia increases with higher dosages in the elderly, the dosage should be limited to 15 mg in these patients. Caution patients about driving or drinking alcohol during therapy. Contraindicated in pregnancy and hypersensitivity to flurazepam.

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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The Healing Process Through Art

Bette Johnson and Pat Stefanini help in the healing proc-ess. They do this at the Pavilion Gallery at Burlington Coun-y Memorial Hospital, Mount Holly. Through an ingenious program, commissioned artwork at the hospital has stimu-lated patients, physicians, nurses, administration, and sup-port health care staff alike—in a positive and enlightening manner.

This unique project was funded by the New Jersey State Council on the Arts. A statewide competition was held to find New Jersey artists who worked in the "realist" tradition. Four artists were chosen: Chris M. Zmijewski, Constance Bottinelli, Nancy H. Shand, and Marvin Friedman. These artists spent several weeks studying and observing the be-hind-the-scenes world at the hospital in an effort to create a realistic impression of the medical world.

The finished paintings were on display at the Pavilion Gallery and at Hahnemann University Lobby Gallery at Hahnemann Medical College and Hospital, Philadelphia. Both Johnson and Stefanini noted, "The impact on the medi-cal profession and art world has been equally dynamic, creat-ing an electricity that stimulates and encourages. It nurtures our ideas and plans for the place of art in healing."

Our cover illustration is a section of an oil painting, "This Is My Whole Life," by Constance Bottinelli. This painting, and all the others, communicate a life dedicated to medicine in a new and exciting manner. G.H.



N.H. Shand, C. Bottinelli, M. Friedman, and C.M. Zmijewski

Annual Meeting Changes

The Board of Trustees of the Medical Society of New Jersey at the September 18, 1983, meeting approved changes in the dates of the 1984 Annual Meeting to Thursday, May 3, 1984, through Sunday, May 6, 1984.

The Inaugural Reception and Dinner-Dance will be held on Saturday, May 5.

Please note the House of Delegates will have its opening session on Thursday. The election session will be held on Friday and the last session of the House will be held on Sunday, May 6.

All Scientific Sessions will be held on Saturday, May 5. The Committee on Annual Meeting believes the changes will streamline the flow of the meeting better to serve and satisfy the membership who attend.

The Annual Meeting, the most prestigious gathering of the Medical Society of New Jersey, is an opportunity to learn of the changes that are taking place in the practice of medi-cine, as well as socioeconomic and political developments.

All physicians are urged to attend this meeting to help guide the future of medicine. The meeting provides an op-portunity for social contact with your colleagues as well as scientific sessions, which are accredited for continuing medi-cal education.

Plan on attending this 218th Annual Meeting.

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THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 2

Prolongation of Life: When Should We Stop?

JAMES E. GEORGE, M.D., J.D., and MADELYN S. QUATTRONE, J.D.*

The application of recent advances in medical science and technology has made it possible to forestall the moment of death for many patients. Matters once left to mere fate now require medical decision making. Depending upon the clinical circumstances, physicians must decide whether the seriously ill patient is an appropriate candidate for medical or surgical intervention, such as kidney dialysis, organ transplantation, or cardiopulmonary resuscitation. A correlative question is raised with regard to the withdrawal of life-prolonging efforts.

Physicians, ethicists, theologians, attorneys, and economists have explored and debated the thorny issues which surround decisions to engage in or forego efforts to sustain the lives of patients who would otherwise die. Media coverage of recent controversial treatment decisions, some of which have led to lawsuits and the imposition of criminal charges of homicide against some physicians, has resulted in significant public awareness of the problems involved.

This article presents a brief overview of some of the medicolegal issues involved in reaching treatment decisions for seriously defective newborns and for the treatment of the terminally ill adult. Various attempts made by the medical community and by the courts to resolve some of the more troublesome issues will be discussed. Physicians who seek additional guidance in this area may wish to consult the report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment,* United States Government Printing Office, Washington, 1983.

THE DEFECTIVE NEWBORN

The birth of a seriously defective newborn (an infant who is not likely to survive without surgical and medical intervention) presents parents, physicians, and hospitals with life and death questions which demand resolution. Much debate and controversy has centered on two types of congenital abnormalities, meningomyelocile (spina bifida) and the combination of permanent irremediable brain damage and surgically correctable but life-threatening problems, such as gastrointestinal abnormalities or congenital heart defects. Arriving at a prognosis and choosing the appropriate therapy, if any, is difficult for all concerned. Several recent studies have revealed that physicians and parents, for years, have been quietly making the difficult decision to withhold medical or surgical intervention when the prognosis is poor for maintaining a meaningful existence. These decisions have generally been made without review by courts or by any institutional organization. Recently, however, the attention of the media has focused on several controversial treatment decisions.

Noteworthy is the case of "Baby Doe" as he was called in legal documents filed with the courts in Indiana. Baby Doe was born afflicted with Down's syndrome and also a congenital esophageal deformity which prevented him from taking food by mouth. His parents refused to consent to the surgery which would have saved his life. Hospital officials went to court asking if the parents could legally refuse consent. The court ruled the parents could legally refuse to consent to surgery. The decision was immediately appealed and, when the infant was five days old, the Indiana Supreme Court, after two hours of arguments, allowed the lower court ruling to stand. On the sixth day, as attorneys prepared to appeal the case to the United States Supreme Court, Baby Doe died.

In response to the events, the United States Department of Health and Human Services issued a regulation which required hospitals receiving federal funds to post notices in

*From the Department of Professional Liability Control, MSNJ, where Dr. George is Director and Editor of PLB and Ms. Quattrone is Assistant Editor of PLB. Correspondence may be addressed to A. Ronald Rouse, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

hospitals units and nurseries prohibiting "discriminatory failure to feed and care for handicapped infants." Violations were to be reported to the federal government on a toll-free, 24-hour hotline. Government investigators would look into all complaints.

In a successful legal challenge brought by the American Academy of Pediatricians, a federal judge struck down the regulation, finding that the government had acted unlawfully in failing to allow the required 60 days of public comment before the regulation was made effective. The judge said that the solution to the rising public debate over the role of physicians and parents in decision making with regard to defective newborns was not in a "hasty, ill-considered 'hotline' informer rule." He observed that without an accepted standard of care for severely deformed infants, the rule set up an enforcement mechanism without defining the violation. (*American Academy of Pediatrics v Heckler,* No. 83-0774, U.S. District Court for the District of Columbia, April 14, 1983.) Legislative attempts to redraft the regulation have been in progress for several months.

The decision of the Indiana Supreme Court to allow the parents of Baby Doe to refuse surgery was met with nearly universal criticism. Criticism of the decision to allow the parents to refuse to consent to life-saving surgery for their Down's syndrome child is based on the generally held belief that an otherwise healthy Down's syndrome child certainly could benefit from such life-saving treatment.

A more difficult question is whether a physician should intervene to perpetuate the life of an infant born with serious multiple defects which, if treated, may permit the child to live a life of extreme hardship. Similarly, a deep division exists among physicians over the appropriateness of the technique known as "total parenteral nutrition" for infants and young children who have nonfunctioning small intestines. Some of these children have been fed intravenously for more than a decade since their births. Some have regained intestinal function while others have been confined for years to life in a hospital, under constant threat of infection, hemorrhage, liver disease, and nutritional imbalance.

It is likely that courts increasingly will be faced with cases in which they are asked to decide when and under what circumstances treatment can be withheld from a seriously defective newborn. In October 1983, a New York Appellate Court ruled in favor of parents who had refused to allow surgery for their 11-day-old daughter born with spina bifida and other defects. The case is on appeal to the highest court of New York at the time of this writing.

Generally, the law has recognized the authority of parents to make decisions which affect the welfare of family members. Increasingly, courts are recognizing a constitutional right of privacy in this area as well. Where courts have been asked to order medical treatment for older children over their parents' objection, judges have given approval when medically accepted treatment is likely to save the life of the child (e.g., blood transfusions have been ordered over the objection of Jehovah's Witness parents). When courts have ordered treatment over parental objection, courts have been carrying out the authority of the state to protect children. In the exercise of its parens patriae power, the state also may punish parents and others whose conduct amounts to abuse or neglect of a child. The threat of the imposition of criminal charges against parents and physicians also remains whenever a decision to withhold life-sustaining treatment from an infant is made.

Against this background, physicians and parents who are confronted with a seriously defective newborn must arri at a treatment decision.

Some helpful guidelines may be found in the report of t President's Commission, *Deciding to Forego Life-Sustaini Treatment.* The Commission concluded that "within the co straints of equity and availability, infants should receive therapies that are clearly beneficial to them." It conclud that an otherwise healthy Down's syndrome child shou receive surgery to correct remediable complications becau the child clearly would benefit from it. The Commission al concluded that therapies which are expected to be futile ne not be provided for a seriously ill newborn; however t infant's comfort should be assured.

The Commission concluded that parents generally are t appropriate parties to make decisions affecting the care their defective newborn, unless the parents are disqualifi from decision making because of legal or other incapacit Where the parents are not the appropriate decision make courts may designate surrogates to serve in the place of t parents.

The Commission noted that the role of informed conse must play a large part in the decision-making proces Parents must be told all relevant information pertaining t the diagnosis and prognosis. Parents also should be informe of any available treatment options and their risks and be efits. Parents also should be informed of the prognosis if n treatment at all is provided. Appropriate consulting medic specialists also should share in the decision-making proce along with the attending physicians.

The Commission also suggested that hospitals develop policy which would require appropriate review of decisior in these cases and in cases where review would assist parent in resolving differences between themselves.

"DO NOT RESUSCITATE" ORDERS

A treatment decision commonly made by attending phy sicians is the decision of whether to withhold resuscitatio efforts from a terminally ill adult patient who may experienc cardiac arrest.

Today, cardiopulmonary resuscitation (CPR) followin cardiac arrest has become routine in hospitals and thei emergency departments. The routine application of CPR ha brought concern that CPR is being applied inappropriately with the result of prolonging death. In 1974, the Americar Heart Association and the National Academy of Sciences in their "Standards for Cardiopulmonary Resuscitatior (CPR) and Emergency Cardiac Care (ECC)" 227 J.A.M.A 837, 864, stated that "cardiopulmonary resuscitation is no indicated in certain situations, such as in cases of termina irreversible illness where death is not unexpected."

Prior to this recognition, physicians, in general, were con cerned that they were required to do everything technologi cally possible to keep alive a terminally ill patient, despite the hopeless prognosis and additional pain and suffering that therapeutically futile intervention might cause. Nevertheless considerable apprehension remained as to whether medically appropriate no code orders were violative of the law.

In 1978, in a case captioned, *In the Matter of Shirley Dinnerstein,* 380 N.E.2d 134, (1978), a Massachusetts Appellate Court held that the issuance of a no code order was appropriate for a patient in terminal stages of an unremitting, incurable terminal illness. The Court ruled that an order not to resuscitate a patient under those circumstances was "peculiarly within the competence of the medical profession

. in light of the patient's history and condition and the ishes of her family."

The Dinnerstein case involved a 67-year-old comatose hos- talized patient in the end stages of Alzheimer's disease. Irs. Dinnerstein was paralyzed totally on the left side as result of a massive stroke. She also suffered from severe 'teriosclerosis.

Mrs. Dinnerstein's family, consisting of a son who is a 'racticing physician, and a daughter, joined with the attend- g physician and the hospital to petition the Massachusetts 'robate Court for declaratory relief. Specifically, they asked .e Court for a determination as to whether the attending 'hysician may issue a no code order without prior judicial 'pproval.

The Massachusetts Appellate Court ruled on the findings f fact made by the Probate Court. It held that a no code rder was appropriate where "attempts to apply resusci- tion, if successful, will do nothing to cure or relieve the inesses which have brought the patient to the threshold of eath."

According to the Dinnerstein Court, a decision to order course of medical treatment which excludes attempts at esuscitation in the event of cardiac or respiratory arrest for ne hopelessly ill patient nearing death, should be made in ght of the patient's history, condition, and wishes of the mily. The Court acknowledged that its decision was in- uenced by the report of the National Conference on tandards for CPR and Emergency Cardiac Care, 227 A.M.A. 837 (1974).

What particularly is important about the Dinnerstein case that the Court held that the decision to withhold resusci- ative efforts is not one for the Court to make. Rather, it , "for the attending physician in keeping with the highest radition of his profession."

The Court noted that a physician's decision to issue a no ode order will be subject to Court review in the event that e is charged with failing to exercise the "degree of care and kill of the average qualified practitioner, taking into account ne advances of the profession." This means that the phy- ician always retains responsibility and potential liability for he negligent issuance or implementation of no code orders.

The risks of an inappropriate decision in this area can be inimized greatly if the decision to avoid resuscitation is rrived at in accordance with accepted criteria or guidelines.

Various state medical societies and organized members of nedical staffs of hospitals have worked diligently over the ast few years to devise guidelines for physicians for the ntry of orders not to resuscitate.

It generally is agreed that orders not to resuscitate should e entered in the patient's record with full documentation y the responsible attending physician. Documentation hould include the patient's prognosis and the patient's in- formed consent if he is competent, or if the patient is in- competent, the family's concurrence.

The constitutionally based right of a competent adult pa- ient to determine what is to be done with his body may be nterpreted as obliging the physician to ascertain the ter- minally ill patient's wishes in regard to CPR efforts and their ikely consequences. Where the physician determines that uch a discussion would not be in the best interests of the patient, this conclusion and its rationale may be documented n the medical record. If the physician and the patient's family concur that CPR should be withheld, then a "do not resuscitate" order may be written.

Where the dying patient's preference cannot be obtained on account of the patient's incompetency, the assessment of incompetency should be documented along with full documentation of his medical condition and prognosis. A medically appropriate order not to resuscitate may be written with the concurrence of the patient's family.

It generally is agreed that patients for whom DNR orders are written continue to be candidates for all other care. Thus, orders regarding supportive care should be written on the patient's chart. No code orders should be reviewed periodically to ensure that the order remains appropriate.

The President's Commission suggests that hospitals develop explicit policies and procedures governing "do not resuscitate" orders. It also suggested that the policy provides for resolution of disagreements on DNR decisions so that recourse to the courts generally would be unnecessary.

WITHDRAWAL OF LIFE SUPPORT

The ability to sustain the lives of permanently comatose or vegetative patients for indefinite periods of time has raised concern over the meaning and quality of life in such a condition. Should life-support systems be withdrawn from patients whose prognosis is a permanent vegetative state?

In 1976, the New Jersey courts faced the issue of termination of a life-support system where the patient's prognosis excluded any reasonable possibility of a return to a cognitive, sapient state. The seminal decision, *In Re Quinlan,* 70 N.J. 10 (1976), held that under certain circumstances, no criminal or civil liability could be imposed upon a physician who removes a respirator from an irreversibly brain-damaged comatose patient.

A brief recitation of the facts of the Quinlan case are as follows. Karen Ann Quinlan was admitted to the hospital suffering from a coma of unknown etiology. Various laboratory tests indicated that her condition may have been the result of the simultaneous ingestion of barbiturates and alcohol. Several days later, Karen was transferred to the intensive care unit of another hospital. At this point, Karen's life was being sustained by a respirator.

A neurologist concluded that Karen was definitely in a chronic or persistent vegetative state characterized by decortication of the brain. Karen was unable to breathe spontaneously without a respirator. Attempts to wean Karen from the respirator were unsuccessful.

It is generally accepted that the initiation or continuance of life-prolonging treatment is inappropriate in some clinical situations.

As the possibility of recovery diminished, Karen's family concluded that the medical devices sustaining Karen's life should be removed. The Quinlans requested the doctors to discontinue use of the respirator. When the attending physicians and the hospital unanimously rejected this demand, Mr. Quinlan sought a court order authorizing the physicians to disconnect Karen's life support system. A guardian was appointed by the court for purposes of representing Karen's interests.

The lower court heard the testimony from the attending physician and expert neurologists. Several experts testified that she had brain stem function but no cognitive ability.

Experts concluded that there was no reasonable possibility of Ms. Quinlan's ever emerging from her vegetative, comatose state into a cognitive, sapient state.

The court also heard statements attributed to Karen that she would not wish to be kept alive by the use of "extraordinary medical devices." The lower court refused to issue an order to withdraw the respirator. An appeal was heard by the New Jersey Supreme Court.

The Supreme Court allowed the guardian of the comatose patient to authorize the attending physician to terminate the life-support system. It noted that all medical experts had testified that there was no reasonable possibility that Karen would ever recover from her comatose state. The Quinlan Court held that the decision attributed to Karen to end her vegetative state by natural means was a right to privacy guaranteed by the Consitution and that this right could be asserted by her guardian. It concluded that the decision to terminate could be made if the guardian and hospital ethics committee concur with the attending physician's decision that the life-support apparatus should be disconnected. It said that the termination of life support under such circumstances would not subject any participant to criminal or civil liability.

The Court also discussed the involvement of the judicial system in what has traditionally been under the exclusive domain of the medical profession. The Court concluded that judicial intervention in every "termination of life support" case would be both impractical and improper. Rather, the Court "assumed" into existence what have come to be known as ethics or prognosis committees in New Jersey. Immediately following the Quinlan decision, the attorney general, the Board of Medical Examiners, and the commissioner of the department of health drew up guidelines to implement the Court's directives in the Quinlan decision.

According to the guidelines, the basic decision-making procedure would be as follows. When the responsible attending physician(s) concludes that there is no reasonable possibility of the patient's ever emerging from a comatose condition to a cognitive, sapient state and when the life-support apparatus being administered to the patient should be discontinued, upon concurrence with the patient's family, they should consult with the prognosis committee (or similar body) serving the institution in which the patient is confined. If the prognosis committee agrees that there is no reasonable possibility of the patient's ever emerging from a comatose state to a sapient state, the life-support system may be withdrawn. The withdrawal may be done without any civil or criminal liability on the part of any participant.

The prognosis committee is activated by a written request from the hospital's administrator or from the patient's family, guardian, or attending physician on behalf of the family. Disciplines represented on the committee shall be: general surgery, medicine, neurosurgery or neurology, anesthesiology, and pediatrics where appropriate. At least two additional physicians from outside the staff of the hospital shall be selected to serve on the committee. Board certification in a specialty is highly desirable for physicians who serve on prognosis committees. The attending or treating physician under no circumstances may serve on the committee.

The committee shall review all relevant patient records, with the family's consent, and shall seek additional medical information concerning the patient from those nursing personnel and other professionals where appropriate. The committee shall also determine which member or members will conduct a complete examination of the patient.

If the prognosis committee agrees that there is no reasonable possibility of the patient's ever emerging from a comatose condition to a cognitive, sapient state, the life-support system may be withdrawn and said action shall be without any civil or criminal liability therefore on the part of any participant, whether guardian, physician, hospital, or other.

The function and responsibility of the prognosis committee is limited to the application of specialized medical knowledge to a particular case to arrive at a determination of concurrence or nonconcurrence with the prognosis of the attending physician. Once that determination has been made and reported, the committee has discharged its responsibility. The attending physician, guided by the committee decision and with the concurrence of the family, then may proceed with the appropriate course of action and, if indicated, shall personally withdraw life-support systems.

Physicians should consult their hospital medical staff bylaws, rules, and regulations for further guidance in this area. Physicians who practice in hospitals which as yet have no organized prognosis committee should not hesitate to call upon appropriately trained colleagues to assist in the de-

In the Quinlan decision, the New Jersey Supreme Court enunciated a standard which protects the physician's reasoned exercise of medical judgment and protects families in their exercise of ethical decisions.

cision-making process. Consulting physicians should document carefully the results of their physical examination of the patient, as well as review of the medical record in support of their ultimate determination.

The Quinlan decision contains numerous ambiguities which are yet to be resolved. For example, the court did not define "life-support systems." In a case decided by the New Jersey Superior Court, Appellate Division, on July 8, 1983 *In Re Conroy,* 190 N.J. Super. 453 (App. Div. 1983), the Court was asked whether a nasogastric tube could be removed lawfully from a patient suffering from severe organic brain syndrome.

The patient, Claire Conroy, age 84, was confined to a nursing home. She was diagnosed as terminally ill and was unable to speak for herself. The patient's only living relative, her nephew, asked the Court to authorize removal of a feeding tube that was keeping her alive. He argued that his aunt had a constitutional right to forego any "extraordinary" efforts to prolong her life.

The lower court granted the petitioner's request and ordered the feeding tube removed. However, the order was never carried out since Miss Conroy's court-appointed guardian won an immediate order banning removal of the feeding tube. Miss Conroy died two weeks after the lower court issued its ruling. Nevertheless, the Appellate Division agreed to hear the case because in its view the issues required resolution to provide guidance to family members, guardians, physicians, and hospitals in the future.

In a unanimous decision, the Appellate Court reversed the lower court's decision. It ruled in the Conroy case that removal of the feeding tube would "constitute homicide"

ıd violate a fundamental medical principle of medical eth-
s to "do no harm." The Court distinguished the Conroy
ıse from the Quinlan case noting that Miss Conroy had
khibited many signs of life and was not comatose or in a
ersistent vegetative state as was Karen Quinlan. The Court
ı the Conroy case said that any decision removing a life-
ıpport system should be limited to incurable and terminally
l patients who are irreversibly comatose or vegetative and
ho would gain no medical benefit from continued treat-
ıent. The Court in the Conroy case also noted that the
asogastric tube was merely a simple device which was part
f Miss Conroy's routine nursing care and was not "medical
reatment." The court said that it would not attempt to
efine the legal difference between medical treatment and
ourishment except for the following: "We hold only that
hen nutrition will continue the life of a patient who is
either comatose, brain dead, nor vegetative, and whose
eath is not irreversibly imminent, its discontinuance cannot
e permitted on a theory of a patient's right to privacy or
ndeed on any other basis." It continued: "If, as here, the
atient is not comatose and does not face imminent and
nevitable death, nourishment accomplishes the substantial
enefit of sustaining life until the illness takes its natural
ourse." It said: "Instead of easing her passage from life,
he result of the judge's order would have been to inflict new
uffering. Such a result has frightening implications. Put
imply, to allow a physician or a family member to discon-
ect life-sustaining treatment to a person solely because that
erson's lack of intellectual capacity precludes her from en-
oying a meaningful quality of life would establish a danger-
ous precedent that logically could be extended far beyond
he facts of the case before us."

The Supreme Court of New Jersey has agreed to hear the
Conroy case. As of this writing, the state's highest court has
ıot yet issued its opinion.

Until the issue is clarified by the State Supreme Court,
or by the legislature, physicians should be guided by hospital
olicies drawn in accordance with the Court's directives in
he Quinlan case whenever the question of withdrawing life
support arises.

RISK OF CRIMINAL SANCTIONS

New Jersey physicians can take some measure of comfort
rom the fact that the New Jersey attorney general has en-
dorsed the guidelines for withdrawal of life support referred
o earlier in this article as meeting the legal requirements of
he New Jersey Supreme Court in the Quinlan decision.
Nevertheless, recent reports of the prosecution of physicians
n other states for "pulling the plug" can lead to legitimate
eelings of apprehension.

In May 1983, Los Angeles prosecutors charged two physicians with murder who terminated life support for a comatose patient. An extensive report of the facts surrounding these charges has been published in *American Medical News,* September 16, 1983. A brief summary based on that report follows.

The patient was a 55-year-old man who underwent surgery for a colostomy closure. While in the recovery room, he suffered a cardiopulmonary arrest. The recovery room was staffed by only one nurse at the time. A code was called and the patient lapsed into a coma. The attending physicians, believing that the patient's condition was hopeless, and having been told repeatedly by the patient's wife and eight children not to prolong the patient's death, wrote orders at 42 hours after arrest not to resuscitate the patient. Orders were written to remove the respirator at three days, and at five days to remove IVs. Another order, to discontinue an endotracheal misting device, apparently triggered a heated argument with a nurse, who then brought the case to the attention of the authorities. Subsequently, Los Angeles, California, prosecutors brought murder charges against the two physicians. After a six-week preliminary hearing, a municipal court judge dismissed the murder charges. Two months later, a Superior Court judge ruled that California law had not been properly applied and reinstated the murder charge. As this article was being prepared, we were advised by AMA news staff that a California Appellate Court ruled that the murder charges against the two physicians must be dropped. The Appellate Court viewed the physicians' "omission to continue treatment under the circumstances, though intentional, and with knowledge that the patient would die, was not a unlawful failure to perform a legal duty." Unfortunately, the California Appellate Court's opinion provides little guidance to physicians.

CONCLUSION

The medical community, the legal system, and society must confront and resolve the serious issues of whether and when to institute or terminate life-saving treatment. This article has presented a brief overview of a few of the troublesome aspects of the problems. A few clear guidelines emerge.

The voluntary choice of a competent and informed patient should prevail. Where the patient is incompetent to reach a decision, a medically appropriate decision should be made in concurrence with the patient's family or guardian. When in doubt, it is safest to err on the side of preserving life. Where the patient is permanently unconscious, the physician should, with the concurrence of the patient's family, seek the assistance of a hospital prognosis committee, where available. Where no such mechanism exists, physicians should obtain appropriate consultations and avoid deciding in haste.

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The Organized Medical Staff: MSNJ Viewpoint

The Joint Commission on Accreditation of Hospitals is revising its guidelines which are applicable to the organized medical staff. There is considerable debate over the proposed revisions both within New Jersey and nationally. Much of the controversy centers over whether or not nonphysicians should be considered for appointment to the active medical staff and to the executive committee of the medical staff. The problem further is complicated by the fact that the State Department of Health is proposing revisions to its regulations regarding the composition of the medical staff and its executive committee.

COMPOSITION OF THE MEDICAL STAFF

The Medical Society of New Jersey believes that only individuals licensed to practice medicine should become members of the active medical staff. Consequently, the executive committee of the medical staff should be comprised entirely of physicians.

PRACTITIONERS WITH LIMITED LICENSES

Practitioners, such as dentists and podiatrists, do have a right and a need to utilize hospital facilities to treat their patients. In order to accommodate these practitioners, an adjunct staff to the medical staff can be utilized with technical committees being organized to address the particular concerns of these individuals. The technical committees should report to the executive committee of the medical staff. The medical staff has responsibility for the quality of all care rendered in the hospital since it is acting as the agent of the governing board. Consequently, it must have the authority to discharge that responsibility and logically can consist only of licensed physicians.

STATE DEPARTMENT OF HEALTH LICENSURE REGULATIONS

The State Department of Health is proposing regulations regarding medical staffs. The Medical Society of New Jersey and the New Jersey Hospital Association have analyzed carefully those proposals and the entire issue of hospital inspection. Both organizations have reached the conclusion that a separate state system is unnecessary and confusing in addition to being costly and time consuming. As a result, they have taken the position that JCAH accreditation and approval should be granted "deemed" status.

At its meeting on September 15, 1983, the Health Care Administration Board voted to withdraw the regulations being proposed by the Department of Health and to continue current regulations for one year. Additionally, it requested that the Department staff meet with the JCAH, the New Jersey Hospital Association, and the Medical Society of New Jersey to develop regulatory language that will be mutually acceptable to all parties.

Members of hospital governing boards actively should support the goal of recognizing JCAH approval as "deemed" status for state licensing purposes. V.A.M.

*The material for this column is coedited by Arthur Krosnick, M.D., Editor of *The Journal*, MSNJ; Vincent A. Maressa, Executive Director, MSNJ; and James E. George, M.D., J.D., Director of the Department of Professional Liability, MSNJ.

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References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., when pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical or Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is insufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. When patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure in whom digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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Analysis of Sodium Content of Community Water Supplies

GEORGETTE KORCH, M.S., R.D., RUKMANI RAMAPRASAD, M.S.,
LEAH ZISKIN, M.D., Trenton*

Drinking water may account for up to 10 percent of an individual's usual daily sodium consumption. Most of New Jersey's community water supplies provide water within the recommended level of 50 ppm sodium, but some supplies in Essex, Gloucester, Ocean, Salem, and Warren Counties exceed this level. Persons with hypertension or other health problems that require restriction of sodium intake should be advised of the sodium content of their local water.

The relationship between sodium intake and high blood pressure continues to be the subject of investigation and debate. According to a report by Dahl and the Framingham Study, hypertension is common in populations that consume approximately 9,200 mg (9.2 gm) sodium a day, and rare in populations which consume 1,400 mg (1.4 gm) or less of sodium a day.[1] Other studies have indicated that the consumption of sodium exacerbates high blood pressure in those individuals who are salt sensitive. In Dahl's classic study, blood pressure was increased in salt-sensitive rats fed a high sodium chow.[1,2]

Salt in the diet comes from three sources: 1) salt naturally occurring in food and water (25 to 40 percent of all salt consumption); 2) salt added during food processing (40 to 50 percent of total salt consumption); and 3) salt added during cooking or added as a condiment at the time of eating (25 to 40 percent of the total salt consumption).[3]

According to current estimates, Americans consume 6 to 18 gm of salt (1 to 3 teaspoons) or approximately 3 to 8 gm of sodium per person per day while the daily physiological requirement is estimated to be 0.4 to 0.8 gm of sodium (¼ teaspoon).[4-6] However, the Food and Nutrition Board (FNB) of the National Research Council (NRC) recommends a level of salt consumption of 2.8 to 8.4 gm of salt per person per day.[7]

When one considers the amount of water consumed as beverage, beverage component, or used in meal preparation, a typical consumption of two liters of water per person may account for up to 10 percent of an individual's usual daily sodium consumption.[4,8] While salt consumption from dietary sources has been studied, the sodium intake contributed by drinking water not always is taken into account.

METHODS

The New Jersey Department of Health, Hypertension Program, in cooperation with the Bureau of Potable Water in the Department of Environmental Protection's Division of Water Resources, reviewed the status of sodium levels in the state's drinking water, in an effort to determine the sodium content of community water supplies in New Jersey. The results of this study were provided to New Jersey residents and health care professionals who counsel persons on restricted sodium diets.

The data were collected utilizing the Department of Environmental Protection's files on community water supplies. A median value of all sodium analyses collected by the Bureau of Potable Water was calculated. The ranges of 51 to 100 and over 100 ppm sodium are reported to provide an indication of the degree of sodium infiltration in excess of the state's recommendation.

RESULTS

Sodium values of finished water in New Jersey's drinking water range primarily from 0 to 50 ppm for the majority of water supplies. However, in Essex, Gloucester, Ocean, Salem, and Warren Counties there are some supplies in which the median sodium levels range between 51 and 100

*From the New Jersey State Department of Health. Correspondence may be addressed to Ms. Korch, New Jersey State Department of Health, CN 364, 120 South Stockton Street, Trenton, NJ 08625.

ppm (Table 1). In fact, some supplies in Gloucester, Salem, and Warren Counties distribute water in excess of 100 ppm sodium with the highest recorded level being 255 ppm (Table 2).

DISCUSSION

As the American Heart Association has indicated, a limit of 20 mg/liter or parts per million (ppm) sodium is desirable as a standard to protect those suffering from heart or kidney ailments.[4,9] The Environmental Protection Agency (EPA) on August 27, 1980, amended the National Interim Drinking Water Regulations to read: "That sodium levels of 20 mg/L or less in drinking water be considered as optimal."[10] While this amendment establishes reporting and notification requirements for sodium, it does not provide for a federally mandated contaminant level for sodium.[10] However, the New Jersey State Department of Environmental Protection (DEP), in the Potable Water Standards, has established a recommended level of 50 mg/L of sodium as the maximum. In accordance with the federally mandated notification regulation, the DEP requires that water suppliers notify appropriate health officials of sodium levels within three months of the required testing.

While the median values cited in the report are factual, the reader must be aware of many variables which can cause considerable fluctuation in sodium values. In addition to low stream flows and the resultant lack of dilution during periods of drought, the type of water source is another variable affecting sodium content. Ground water supplies maintain a more consistent level of sodium, whereas surface supplies are affected by factors such as road salting. Runoff from road salting occurs in winter months, particularly in areas where the drainage from roads may be to rivers and/or lakes from which water purveyors downstream pull water. In such instances, it is possible that sodium levels may be greater than cited here.

While the values cited included water treated with sodium compounds, it was not within the purview of the project to consider home water softeners. However, the utilization of home water softeners in effect can convert a water supply which is low in sodium to one high in sodium. It is estimated that for each milligram per liter of hardness removed as calcium carbonate by the exchange process, the sodium content would be increased by one-half milligram per liter.[9] In addition to the higher levels of sodium in soft water, many authors, including Bierenbaum et al. have cited the negative correlation between cardiovascular disease mortality rates in the United States and the level of hardness of water.[11]

RECOMMENDATIONS

If a water softener is utilized, home owners should consider not connecting kitchen lines to the water softeners, allowing the kitchen or drinking water lines to remain "hard" but free from sodium while allowing clothes to be washed in soft water. Another alternative is to connect only the hot water lines to the water softener.

This study concentrated on the community water systems in New Jersey that provide water to approximately 85 to 90 percent of the state's population,[12] but it was beyond the scope of this project to survey the 300,000 to 400,000 private wells in the state.[12] We resisted temptation to extrapolate the findings cited here to private wells located in the same area, because fluctuations in sodium levels within a geographic area do occur.[12] Factors such as outdoor storage of road salt or use of salt on sidewalks, as well as proximity of septic tanks to a private well, may influence sodium levels.[11] Therefore, it is recommended that owners of private wells have their water analyzed for sodium content.[12]

TABLE 1
Community Water Supplies: 51 to 100 ppm Sodium

County	Median Value
Essex County	
South Orange Water Dept.	94
Gloucester County	
East Greenwich Twp. Water Dept.	92
Edenwood Water Co.	94
Mantua Water Co.	82
Manor Water Assoc., Inc.	68
Sewell Water Co.	79
National Park Water Dept.	53
Swedesboro Water Dept.	51
Wenonah Water Dept.	60
West Deptford Twp. Water Dept.	55
Woodbury City Water Dept.	73
Ocean County	
Barnegat Light Water Dept.	68
Salem County	
Elmer Boro Water Dept.	62
Penns Grove Water Supply Co.*	91
Warren County	
Pequest Water Co.	66

*Has two well fields: one of which is high In sodium while the other is low in sodium.

TABLE 2
Community Water Supplies over 100 ppm Sodium

County	Median Value
Gloucester County	
Clayton Water Dept.	189
Glassboro Water Dept.	130
South Jersey Water Supply Co.	160
Pitman Water Dept.	104
Salem County	
Woodstown Boro Water Dept.	186
Warren County	
Hillcrest Homeowners Water Assoc.	101

In New Jersey there are an estimated one million uncontrolled hypertensives.[13] Once identified, each individual should be encouraged to reduce salt, or more specifically, sodium consumption. Since the food sources of sodium are well known, hypertensives and others who follow a low dietary sodium regimen should receive extensive counseling on those foods which are contraindicated.

While many New Jerseyans are concerned about their dietary intake of sodium, (almost 4 percent of the adult population, or over 160,000 persons in New Jersey are estimated to be on reduced sodium diets), these individuals must monitor their diets carefully to avoid all unnecessary sources of sodium.[14] Persons on severely restricted sodium diets (500 mg sodium/daily) can consume only water which contains at most 20 mg/L sodium.[15] While such a severely restricted diet is quite uncommon in the "free-living" population, diets allowing 1,000 mg sodium are more common. At this level of restriction, an individual who consumes two liters of water containing as much as 270 mg/L sodium, must adhere to the same stringent dietary protocols of the 500 mg/L sodium

liet." However, if two liters of water containing 20 mg/L odium are consumed, the dietary sodium consumption can e more liberal. Persons on a more liberal sodium diet, such s 2,000 mg sodium and above, must consider the contribuion of sodium in the drinking water. This information is vailable from the local water company.

SUMMARY

Sodium levels of the majority of community water supplies hroughout the state are acceptable for the general popuation. However, residents of Essex, Gloucester, Ocean, Salem, and Warren counties should be informed that their ommunity water supply may exceed 50 ppm. Residents of ome areas in Gloucester, Salem, and Warren Counties may e consuming water containing in excess of 100 ppm.

Many factors cited here contribute to fluctuations in the odium content of potable water and individuals requiring uch information should be advised to obtain it from their vater supplier.

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Leaving
the psychotic
symptoms of
Organic Brain
Syndrome
behind.



Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information.

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Concentrate 5 mg/ml

Intramuscular 2 mg/ml 5 mg/ml



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BRIEF SUMMARY OF PRESCRIBING INFORMATION

Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml

Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered.

Warnings: *Usage in Pregnancy*—Safe use of this drug during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. Administration of repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen (See Precautions.)

Usage in Children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although it can potentiate the action of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants or with convulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Neuroleptic drugs elevate prolactin levels, the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis; the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration—As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children. Patients only with adequate muscle development and proper injection technique should be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions: Note: Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects: Tachycardia, fainting, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

CNS effects: Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy. The incidence of extrapyramidal symptoms is similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia. As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.

There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign o syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transi have been infrequently observed in some patients. No clinically confirmed cases of jaund attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsych drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thr bocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis sh been reported with Navane. Undue exposure to sunlight should be avoided. Although not exp enced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have b reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occur in a small percentage of females receiving Navane. If persistent, this may necessitate a reduc in dosage or the discontinuation of therapy. Phenothiazines have been associated with fa positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased swe ing, increased salivation, and impotence have occurred infrequently with Navane ther Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in ap tite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship betwe phenothiazine therapy and the occurrence of systemic lupus erythematosus-like syn

NOTE: Sudden deaths have occasionally been reported in patients who have received certa phenothiazine derivatives. In some cases the cause of death was apparently cardiac arres asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor co it established that death was due to phenothiazine administration.

Dosage and Administration: Dosage of Navane should be individually adjusted depending on chronicity and severity of the condition. In general, small doses should be used initially a gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its u have not been established.

Navane Intramuscular Solution: Navane For Injection—Where more rapid control and treatm of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also benefit where the very nature of the patient's symptomatology, whether acute or chronic, rend oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medicatio the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may increased or decreased depending on response. Most patients are controlled on a total da dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg/day. An oral form shou supplant the injectable form as soon as possible. It may be necessary to adjust the dosage wh changing from the intramuscular to oral dosage forms. Dosage recommendations for Nava (thiothixene) Capsules and Concentrate appear in the following paragraphs:

Navane Capsules, Navane Concentrate—In milder conditions, an initial dose of 2 mg three tim daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total da dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the benefic response.

Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivatic dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially is symptomatic and supportive. For Navane oral, early gastric lavage helpful. For Navane oral and Intramuscular, keep patient under careful observation and maintai an open airway, since involvement of the extrapyramidal system may produce dysphagia ar respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures f managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drug Other pressor agents, including epinephrine, are not recommended, since phenothiazine deriv tives may reverse the usual pressor action of these agents and cause further lowering of the bloo pressure.

If CNS depression is present and specific therapy is indicated, recommended stimulan include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants th may cause convulsions (e.g. picrotoxin or pentylenetetrazol) should be avoided. Extrapyramid symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little valu in phenothiazine intoxication.

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Arterial Blood Gas Determination in the Evaluation of Disability in Coal Miners

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A previous study concluded that the addition of blood gas analysis to spirometry detects no greater number of subjects with respiratory impairment than spirometry alone. Hence, we reviewed the records of 52 consecutive claimants who had both performed. Disability was evaluated by two different sets of criteria: Department of Labor interim standards and Department of Labor final standards. Respectively, 4 and 15 percent of claimants qualified for disability by blood gas analysis only. It is concluded that blood gas analysis is useful in the evaluation of disability for coal miners.

The determination of disability for any applicant can be a subjective process fraught with the potential of arbitrary awards. To perform such a procedure properly, it is necessary: to determine whether or not the applicant has the disease that is claimed; and to determine whether or not the applicant has significant physical impairment.

The Department of Labor has adopted rigid criteria, based on pulmonary function and arterial blood gas studies, to determine whether or not applicants for coal miners' disability benefits, judged to have pneumoconiosis by chest x-ray or doctor's evaluation, also can be categorized as disabled.[1]

Morgan et al.[2] evaluated 50 claimants referred for arterial blood gas evaluation and 150 claimants referred for spirometry under the older "interim standards"[3] and concluded that arterial blood gas measurements added little in detecting disability among coal miners. In the following study, we retrospectively reviewed studies performed on 52 applicants who had both spirometry and arterial blood gas measurements using the interim criteria[3] and the final standards adopted in 1980[1] to determine whether or not the addition of arterial blood gas analysis to spirometry can identify a significant group of coal workers who qualify for disability by present standards, and who would be denied disability were arterial blood gas determinations not performed.

METHODS

Records of 60 consecutive applicants referred by the Department of Labor for testing were reviewed. Fifty-two applicants had spirometry and arterial blood gas measurements performed. All were males, characterized by age and height (Table 1). It should be noted that 17 applicants were not taller than 66 inches.

Spirometry was performed using either a 7 or 13 liter water seal spirometer (Warren E. Collins Co.), as appropriate. Subjects were seated and wore nose clips.

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TABLE 1

*Claimants**

	Mean	Standard Deviation	Range
Age (years)	62.2	6.9	46-83
Height (inches)	67.5	2.7	62.5-72.0

*n = 52

All subjects performed at least three forced expiratory maneuvers and three maximum voluntary ventilation (MVV) maneuvers. Traces were inspected for effort and reproducibility and best values were recorded. Arterial blood samples were drawn with the patient at rest in a seated position. When blood samples were obtained after exercise, an 18- or 20-gauge Teflon™ catheter was inserted percutaneously into the radial or brachial artery under local anesthesia. Cardiac rhythm was monitored and the patient was seated on a cycle ergometer (Quinton). The patient started pedaling at a work rate of 200 kilopons (KP). The work rate was increased in 200 KP increments until the patient either was too dyspneic to continue or heart rate reached 80 percent of predicted. Blood samples then were drawn through the cannula while the patient still exercised. Samples were analyzed using a blood gas analyzer (Radiometer Copenhagen PVM 71 MK2).

Data were reviewed to determine how many claimants qualified as having a respiratory disability by spirometry alone, by blood gases alone, by blood gases and spirometry together, and by neither, using the Department of Labor interim standards[3] and the Department of Labor final standards.[1]

RESULTS

Table 2 details the results of the disability evaluation on the 52 claimants who had spirometry and arterial blood gas measurements. Using the interim standards, 48 percent qualified for disability. However, only 2 claimants (4 percent) qualified by blood gas criteria who did not meet spirometric criteria. Review of their records showed that one claimant had been judged to have pneumoconiosis by clinical evaluation and chest x-ray, while the other had not. Using the Department of Labor's final criteria, 33 percent were deemed disabled. Eight claimants (15 percent) were disabled by blood gas criteria, but not spirometric criteria and 6 of those 8 claimants had pneumoconiosis by x-ray and clinical evaluation. Five claimants had simple pneumoconiosis and 1 claimant had progressive massive fibrosis (PMF). Seven of the 8 claimants had a history of smoking. One smoker, felt not to have pneumoconiosis by chest x-ray or examination, had clinical congestive heart failure. Twenty-eight of the 52 claimants had postexercise blood gas measurements. Some subjects were not exercised for the following reasons: physical impairment, such as severe arthritis; refusal of cannula placement; inability to place cannula; significant hypoxia c resting blood gas study obviating the need for postexerci blood gas determination by present criteria; and previou medical evaluation disallowing exercise for medical reason such as angina. Two claimants (4 percent) qualified fo disability by postexercise blood gas values who failed t qualify by both resting blood study and spirometry.

DISCUSSION

While it is difficult to define the exact point in spirometri measurements or Pao_2 above which a claimant can sti perform a job and below which he is too physically impaire to function, it is necessary to attempt to set such criteria fo the award of disability in order to be fair to all claimants an avoid completely subjective awards.

Morgan et al.[2] reviewed their experience with 150 claimants who had only spirometry and 50 claimants who had only blood gas analysis (47 of whom previously had no made disability criteria by spirometry) under the Departmen of Labor interim standards.[3] They concluded that since only 2 claimants qualified for disability by blood gas analysis (after not previously qualifying by spirometry), both o whom did not have pneumoconiosis, that the addition o blood gas analysis to spirometry is unnecessary in the evaluation of coal miners for disability. They do point out that the "interim standards are generous in the extreme and any reduction in FEV_1 or MVV below 80 percent of those values predicted by Kory et al. is regarded as indicating total and permanent disability." An alternate explanation of their findings is that the interim spirometric criteria were proportionately much more lenient than the blood gas criteria. If the spirometric standards were to be made less lenient (as they subsequently were), failure to check for abnormal blood gas values could deprive deserving claimants of disability benefits. The Department of Labor interim standards for spirometry awarded disability if the claimant's FEV_1 and MVV fell below 80 percent of those values predicted by a modification of the formula of Kory et al. for FEV_1. Age was not taken into account and height was only taken into account within the range of 67 to 73 inches. Claimants less than 67 inches needed to meet the same criteria as those claimants 67 inches or taller. Maximum value for MVV receiving disability was determined by multiplying that value of FEV_1 by 40. It was not unusual, under the interim standards, for us to see a claimant qualify for disability and yet be considered normal within our laboratory (and by the unmodified predictions of Kory et al.)[4] As an example, a 65-year-old man, who was 65 inches tall, needed an FEV_1 of 2.3 liters or less and an MVV of 92 L/min or less to qualify for disability. Such values are 85 percent of predicted when using the Kory formula unmodified.

The Department of Labor eventually did adopt spirometric criteria that are more stringent. The final standards use spirometric criteria based on the formulas of

TABLE 2

*Tests By Which Claimants Were Called Disabled**

Criteria	Spirometry Only n	%	Spirometry and Gases n	%	Gases Only n	%	Not Disabled n	%
DOL-interim	11	21	12	23	2	4	27	52
DOL-final	4	8	5	10	8	15	35	67

*n = 52

nudson et al.[3] Values less than 60 percent of predicted now alify for disability. Age (22 to 71 years) and height (51.9 to .7 inches for males) are taken into account. Blood gas teria have been modified from the interim standards, but main similar taking alveolar-arterial oxygen gradient into count. Disability is awarded if Pa_{O_2} falls below a set level pendent upon the $PaCO_2$ or if the $PaCO_2$ is above a set lue. The final criteria may allow disability with a higher O_2 than previous if the $PaCO_2$ is low enough, but excludes vards based on elevated $PaCO_2$ until a higher level is ached. Based on the final standards, 8 claimants (15 ercent) would qualify for disability by blood gases who do ot by spirometry, although the total percent disabled would ave declined from 48 to 33 percent and the total number ualifying by blood gas studies (including those who also ualify by spirometry) has decreased from 14 to 13 claimants `able 2).

Only a small number of those claimants tested by Morgan[2] et any of the interim criteria for disability. Of their 200 aimants, 8 claimants met spirometric criteria and 2 aimants met blood gas criteria (5 percent total) by the terim standards.[1] This is in marked contrast to the 48 ercent of applicants in this study who met the same interim andards for disability. This is not surprising as all of the laimants analyzed here previously had worked in the an-hracite mines of eastern Pennsylvania, where the prevalence f pneumoconiosis is much higher than in the bituminous nines of Appalachia (where most of the miners in Morgan's tudy worked).[6] Using radiographic criteria, Morgan et al.[7] reviously reported the prevalence of simple pneumoconiosis s 45.7 percent and progressive massive fibrosis (PMF) as 4.3 percent in eastern Pennsylvania anthracite mines com-ared to only 4.6 percent and 0 percent respectively for Colorado bituminous miners with Appalachian miners fall-ng in between. For example, 29.4 percent of miners from orthern West Virginia had simple pneumoconiosis (0 ercent had PMF) and 23.4 percent of miners from southern Vest Virginia had simple pneumoconiosis (3.8 percent had PMF).

The term "pneumoconiosis" should not be synonymous with the term disabled. It is possible to have a pneu-noconiosis without being disabled. It also is possible to meet disability criteria through a disease process other than pneumoconiosis. Thus, it is important that for all applicants there be both an evaluation of disability on a quantitative basis and a determination of what the underlying disease is. Morgan et al.[2] concluded that arterial blood gas measurement is unimportant in evaluating disability because the Department of Labor's "interim standards" were used. In contrast, using the final standards, we have found that 8 of 52 miners qualify for disability by blood gas analysis who would not qualify by spirometry. Although 7 of the 8 smoked, 6 miners were judged by both x-ray and physical examination to have pneumoconiosis.

CONCLUSION

This study has made no attempt at analyzing what level of spirographic or arterial blood gas reduction truly causes disability. Since we find 18 percent disabled by spirometry and an additional 15 percent by arterial blood gas analysis (who were not disabled by spirometry) by present Department of Labor standards, we must conclude that complete elimination of arterial blood gas analysis, in the determination of disability awards for coal miners, is not justified at the present time.

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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-receptor stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the first-pass clearance of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for increased dosage should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can be used twice daily for beta-blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The therapeutic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In doses greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved in the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be assessed in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, dyspnea, syncope, and to improve exercise tolerance and performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are adequately digitalized and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking th prior to major surgery is controversial. It should be noted, however, that the impaired abili the heart to respond to reflex adrenergic stimuli may augment the risks of general anesth and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of l receptor agonists and its effects can be reversed by administration of such agents, dobutamine or isoproterenol. However, such patients may be subject to protracted se hypotension. Difficulty in starting and maintaining the heartbeat has also been reported beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the pearance of certain premonitory signs and symptoms (pulse rate and pressure change acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be r difficult to adjust the dosage of insulin

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroid Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symp of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function t

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have b reported in which, after propranolol, the tachycardia was replaced by a severe bradyca requiring a demand pacemaker. In one case this resulted after an initial dose of 5 propranolol

PRECAUTIONS. General Propranolol should be used with caution in patients with impa hepatic or renal function. INDERAL is not indicated for the treatment of hyperten emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patie should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disea elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as re pine should be closely observed if INDERAL is administered. The added catecholam blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthost hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals h been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studie both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signific drug-induced toxicity. There were no significant tumorigenic effects at any of the dose levels. Reproductive studies in animals did not show any impairment of fertility that w attributable to the drug

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic animal studies at doses about 10 times greater than the maximum recommended human do

There are no adequate and well-controlled studies in pregnant women. INDERAL sho be used during pregnancy only if the potential benefit justifies the potential risk to the fet

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and ha rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hyp tension, paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomn lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visu disturbances, hallucinations, an acute reversible syndrome characterized by disorientation time and place, short-term memory loss, emotional lability, slightly clouded sensorium, a decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhe constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergy: pharyngitis and agranulocytosis; erythematous rash, fever combined with achi and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopen purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has be reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male imp tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactio involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolo have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in sustained-release capsule for administration once daily. If patients are switched from INDERA tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeu effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute f INDERAL tablets. INDERAL LA has different kinetics and produces lower blood levels. Refitration ma be necessary especially to maintain effectiveness at the end of the 24-hour dosing interva

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 m INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may b increased to 120 mg once daily or higher until adequate blood pressure control is achieve The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 64 mg may be required. The time needed for full hypertensive response to a given dosage i variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg of INDERAL L once daily, dosage should be gradually increased at three to seven day intervals until optimu response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value an safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few week (see WARNINGS)

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL L once daily. The usual effective dose range is 160-240 mg once daily. The dosage may b increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is no obtained within four to six weeks after reaching the maximum dose, INDERAL LA therap should be discontinued. It may be advisable to withdraw the drug gradually over a period o several weeks

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group ar too limited to permit adequate directions for use.

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REVIEW ARTICLE

Nonpenetrating Cardiac Trauma

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Nonpenetrating cardiac trauma plays a significant part in the morbidity and mortality of trauma patients, especially when the mechanism of injury involves decelerating forces or forces applied directly to the chest and/or upper abdomen. The diagnosis of the more serious sequelae often will be detectable on clinical grounds alone. Myocardial contusion, however, may offer little in the way of clinical clues and may be extremely difficult to diagnose. A careful history from patient, bystanders, and ambulance personnel coupled with a high degree of suspicion is important. The role of diagnostic aids and suggestions for management have been reviewed.

Burchell wrote in 1974, "And always with a heart contusion, arise both doubt and much confusion."[1] It was pointed out in the famous 1965 monograph, "Accidental Death and Disability, the Neglected Disease of Modern Society," trauma is the leading cause of death in people in the United States under age 35.[2] A significant portion of this morbidity and mortality occurs due to injuries to the heart, including those from nonpenetrating chest trauma.

Most surgical textbooks which discuss thoracic trauma include those in the Table—the first six injuries representing an immediate threat to life that must be treated as quickly as possible and the second six injuries representing a "relative" threat, usually requiring somewhat less urgent therapy. A careful physical examination, combined with a single upright chest film, in the trauma victim can lead to a diagnosis (or at least enough of a suspicion to institute further evaluation or treatment) of most of these entities.

MYOCARDIAL CONTUSION

The one major exception to this is myocardial contusion, an injury often not obvious, often not thought of, and often overlooked. Even when suspected, it may be difficult to prove, since the clues we might look for—hemodynamic or EKG abnormalities—may be absent or easily can be mimicked by other simultaneous problems. Although myocardial contusion is a well-recognized entity, it has been studied sparsely, relative to coronary artery disease. We only can estimate its true incidence since it often results in little morbidity or mortality and often goes completely unrecognized. Estimates of cardiac injuries in studies over the past ten years have ranged from 16 percent in moderate trauma to 76 percent in severe trauma.[4] In a 1973 study, of 611 motor vehicle fatalities, 9 percent had cardiac damage at autopsy, 5 percent of sufficient severity to be the sole cause of death.[5]

In that same year, the Medical Examiner of Philadelphia was quoted as saying that blunt cardiac trauma was the most commonly unsuspected visceral injury responsible for death in accident victims.[6] Parmley's study at the Armed Forces Institute of Pathology makes this notion even more confusing. In the largest series studied, over 200,000 autopsied

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TABLE

Immediate Threat to Life

1. Open pneumothorax
2. Airway obstruction
3. Flail chest
4. Tension pneumothorax
5. Massive hemothorax
6. Pericardial tamponade

Relative Threat to Life

1. Aortic rupture
2. Rupture/tear of tracheobronchial tree
3. Rupture of diaphragm
4. Rupture of esophagus
5. Pulmonary contusion
6. Myocardial contusion

patients, Parmley found 546 with significant cardiac trauma; many of these patients also had associated injuries. In the majority, their extra-cardiac injuries were felt to be severe enough to have resulted in death, even had their cardiac injury not been present.[7]

CASE REPORT

A 42-year-old man was struck head-on by a truck while driving his car. He sustained a blunt head injury with approximately a 10 minute loss of consciousness. In addition, he had a fractured femur and multiple contusions and abrasions of his face and chest. Within several hours of admission, his EKG demonstrated Q waves and ST elevations in the anterior precordial leads. His physical examination revealed persistent chest wall tenderness and the development of a II/VI systolic ejection murmur. His chest x-ray showed the development of cardiomegaly over his initial days of hospitalization, with clinical and fluoroscopic evidence of a left ventricular aneurysm. He remained hemodynamically stable until the 14th hospital day, when he developed ventricular tachycardia. Lidocaine (100 mg), followed by another 50 mg, converted the patient to normal sinus rhythm, although he continued to have occasional PVCs. Quinidine ultimately maintained the patient in sinus rhythm. He was well at followup, up to four years after discharge.

HOW INJURIES OCCUR

The exact mechanisms of injury are felt to involve the following forces:[8]

1. **Direct:** Secondary to a discrete blow to the precordium of short duration.

2. **Indirect:** What has been called the "hydraulic ram effect," where blunt trauma to the abdomen causes a sudden increase of venous return and simultaneous increase in intrathoracic pressure from upward displacement of the abdominal viscera or diaphragm, resulting in a sudden increase in intracardiac pressure.

3. **Compressive:** Where more sustained force results in compression of the heart between sternum and vertebrae or sternum and elevated diaphragm.

4. **Deceleration:** Creating a pendulum and/or rotational effect such that the heart moves freely inside the chest relative to its supporting structures; in the classic deceleration injury, the steering wheel, there are three components: vehicle strikes object; driver strikes steering wheel; and heart strikes sternum.

5. **Combination:** Two or more of the above.

Some authors have noted less severe cardiac trauma wh there are overlying rib fractures, presumably because latter absorbed and dissipated some of the kinetic energ Obviously, there are many exceptions to this, and presence of such fractures should not dissuade one fr looking for visceral injury.

It also has been noted that there may be some significar as to when in the cardiac cycle the trauma occurs, as t heart is least compressible (therefore, least able to diffu energy) when filled with blood and thus more susceptible damage.[8] This seems to have more significance with respe to structural disruptions than electrical instability, as shall see.

The most common types of trauma that include the abov named mechanisms seem to stem from our increased d pendence on high-speed transportation, heavy industry, ar mechanized services. By far the most common are mot vehicle accidents (automobile and motorcycle, both passe ger and pedestrian), with steering wheel injuries being hig on the list. After this are industrial accidents, falls fro heights, crush injuries, and athletic injuries.[5] There a reports of sudden death secondary to seemingly trivial blu chest trauma, where a small force of short duration impacte the precordium, e.g. a blow from a stick, pitched or batte ball, or punch during a boxing match. These showed litt evidence of intrathoracic injury at postmortem and presum ably occurred due to lethal arrhythmias.[10]

PATHOPHYSIOLOGY OF BLUNT CARDIAC TRAUMA

The pathophysiology of blunt cardiac trauma is revealed through a combination of animal studies (using either open or closed-chest models) and clinical studies, with or withou autopsy data.

Several primary injuries occur commonly in the setting o blunt cardiac trauma. Lacerations, either superficial or deep small or large, usually with ragged edges, were commonly found in Parmley's series but rarely were a cause of death Death only resulted if an epicardial or pericardial laceration involved a surface vessel, resulting in hemopericardium, o an endocardial laceration involved a valve leaflet or papillary muscle, or there was mural thrombus formation with subsequent embolization.[7]

In Parmley's series, myocardial rupture was the most common lesion found at autopsy (353/546). This either may result from a decelerating force acting on a relatively fixed point of the heart (e.g. the junction of the right atrium and vena cava) or due to trauma during late diastole/early systole when the chambers are full and poorly distensible. Such trauma causes a sudden increase in intraventricular pressure and ruptures either valves, septum, or free wall. Most of these patients with myocardial rupture did not reach the hospital alive. At autopsy, most had ventricular rupture; atrial and septal ruptures were less common. Of the 27 who were alive at arrival at the hospital, 19 had atrial ruptures and 8 ruptured the septum.[7] These would be expected to present with hemorrhagic shock, tamponade, or congestive heart failure.

Bruised muscle also seems to possess a different electrical potential than surrounding tissue. This problem, in combination with hypoxia, acid-base and electrolyte disturbances, and increased circulating catecholamines, may contribute to irritable areas of myocardium generating ectopic impulses or serving as a source of reentrant-type tachyarrhythmias.[8] In

imal experiments, most fatal arrhythmias occurred in the st 10 minutes with a second peak of ventricular ectopy at to 90 minutes, possibly secondary to reperfusion irritabili-. In open-chest dogs with direct cardiac trauma, if they rvived the first 5 minutes without fatal arrhythmias, ntricular irritability gradually decreased from "frequent" VCs at 5 minutes to "occasional" at 30 minutes.[11]

Bradyarrhythmias occur as well. Sinus node dysfunction, ith a traumatic "sick sinus syndrome" has been reported.[12] isruption of the conducting system (such as seen in tears in e membranous portion of the septum) or simply edema or emorrhage into adjacent areas, decreased perfusion with chemia of the AV node, possible local release of metabolic epressants, and activation of vagal reflexes all have been roposed as mechanisms for bradyarrhythmias and conduc-on abnormalities.[13]

"The most common types of trauma are motor vehicle accidents, with steering wheel injuries being high on the list."

There was widespread agreement by most authors, however, that myocardial contusion was the most common lesion ccurring in blunt cardiac trauma. There initially may be ttle evidence of myocardial contusion at the time the patient examined initially—as opposed to several of its complica-ons, as well as some of the other primary lesions already nentioned—myocardial contusion can be extremely difficult o diagnose. In addition, the mortality rate for simple nyocardial contusion is small, so these patients rarely are utopsied.

Grossly, a contusion appears as a dark red hemorrhagic rea, sometimes comprised of multiple petechiae on the urface, sometimes of an area of uniform bleeding into the nuscle. It may be confined to the subepicardial or subendocardial surface, or it may be transmural.[7]

Microscopically, the contused area will differ in appearance depending on the duration of time from the rauma. In patients who die suddenly (e.g. from an arrhythmia or other associated injuries), there may have been o time for any pathologic change to take place. In short-erm survivors, the contused area will appear as a well-demarcated lesion with extravasated red blood cells into the nterstitium and separation and disruption of muscle fibers with loss of striation.[11] The sharp demarcation may divide ndividual muscle bundles, unlike the lesion of ischemic infarction where the transition from normal to abnormal is more gradual. This emphasizes the fact that a pure contusion is different from an ischemic infarction since, in the former, the myocardium is perfused by an intact circulation.

In long-term survivors, there is actual necrosis of cells, with infiltration of leukocytes and fibrin-like strands, both in vessels and in interstitium between muscle fibers. Regional blood vessels also are dilated and congested with increased numbers of leukocytes.[7] Healed contusions also are different from infarcts, the latter with gross scar formation replacing the infarcted zone, the former showing patchy fibrosis within normal muscle tissue.[14]

The differentiation usually is pointed out between cellular destruction due to contusion and that due to infarction, although functionally they may have similar consequences. There also may be some overlap, as patients with underlying coronary atherosclerotic disease are more prone to ischemic myocardial damage, possibly due to thrombotic obstruction of partially stenotic vessels, or to intimal tears, surrounding edema, bleeding into ulcerated plaques, or arterial spasm.[15] Although actual infarction due to coronary artery obstruction in previously normal coronary arteries has been reported, it is rare, and most authors agree, that the coronary circulation seems fairly resistant to the direct effects of blunt cardiac trauma.[16] Rarely, a coronary artery may rupture; this usually requires a very large impact force, as evidenced by frequent damage to other cardiac structures at the same time. Death generally is from tamponade rather than myocardial infarction.[15]

Blunt trauma may have certain functional consequences. Several authors differentiate contusion from concussion. The latter is considered to be a temporary posttraumatic myocardial dysfunction with no detectable histologic evidence of cellular damage, usually diagnosed solely due to transient nonspecific EKG abnormalities.[18] Most of the hemodynamic studies have been done in the laboratory on animals with artificially produced cardiac lesions, some using open-chest techniques, others closed. A number of hemodynamic and/or physiologic abnormalities were noted in the papers reviewed: decreased ventricular compliance; decreased cardiac output (often 30 to 40 percent) and decreased aortic mean arterial pressure (of greater quantity and duration the greater the trauma), occasionally to levels of shock but usually prevented by an increased PVR; mildly increased LV end-diastolic pressure (but rarely enough to cause CHF); a decrease in ventricular dp/dt; a decrease in myocardial O_2 consumption; and a decrease in percent lactate extraction.[11]

Interestingly, some authors found that these changes were global, not only involving the area directly impacted. One group measuring myocardial perfusion and vascular resistance found that blunt trauma resulted in a decrease in coronary vascular resistance with an opening of AV shunts, decreasing perfusion to groups of myocardial cells, and many of the hemodynamic derangements mentioned above. The fact that these abnormalities occurred away from the area of impact led them to suggest the possibility of neural and/or humoral mediators.[17] The problem with such experiments is that they cannot fully recreate real-life events and, although many of these mechanisms may (and probably do) occur in actual patients, the situation probably is much more complex.

Most of the previously mentioned injuries will be detectable either by their measurable or clinical effects on hemodynamic function or by constant EKG monitoring for arrhythmias. Myocardial contusions, however, may occur with no external evidence of chest trauma, and little or no immediate hemodynamic consequences. Survival from major chest trauma does not mean that myocardial contusions have not occurred. Although most patients who do not die early from an arrhythmia usually do not do so later on, this, as well as other delayed complications, are well known with contusion. It may be easiest to think of them as being similar to those of myocardial infarction:

1. **Arrhythmias:** Virtually every arrhythmia has been reported; the incidence seems to have no correlation with the extent of the trauma. Sinus tachycardia is common but may have several etiologies in a patient with cardiac trauma

including hypovolemia, hypoxia, and pain. Atrial flutter and atrial fibrillation are said to be the most commonly seen arrhythmias after blunt cardiac trauma.[7] Premature ventricular contractions, ventricular tachycardia, or ventricular fibrillation are well known and require suppressant medications or electrical conversion. Conduction abnormalities (intraventricular conduction delay, bundle-branch block, AV block) all have been reported;[19] many are transient and others require pacing, some permanently.

2. **Ventricular Aneurysms:** They may cause hemodynamic consequences of decreased pump function, as well as mural thrombi and emboli, when they occur.

3. **Myocardial Rupture (free wall, septal, or papillary muscle):** Rupture may be delayed hours, days, or weeks after the injury, when a contused area becomes necrotic, weakens, and finally ruptures. The second week is considered by some to be the most critical period.[7] Similar to penetrating trauma, rupture of the free wall usually results in death due to exsanguination or tamponade. Immediate pericardiocentesis or thoracotomy with repair may be life-saving. Septal rupture most often occurs in the muscular portion of the ventricular septum, near the apex. The hemodynamic consequences are determined by the degree of shunt; when small, they may be minimal and the person may be managed medically.[7]

4. **Pump Failure:** With congestive heart failure and/or cardiogenic shock, pump failure rarely occurs as a result of contusion alone. If pulmonary edema occurs, it may be noncardiogenic (due to head injury, shock-lung, aspiration, or pulmonary contusion). When pulmonary edema is on a cardiac basis, it is a poor prognostic sign which indicates a significant area of dysfunctional myocardium.

DIAGNOSTIC CRITERIA

Because of the morbidity and mortality associated with these late sequelae, it is important that some criteria be developed that would help us to recognize, or at least to suspect, that the patient has a cardiac contusion. This is where we traditionally would turn to our clinical evaluation and laboratory examinations.

We must apply a high index of suspicion to patients who have suffered blunt thoracic or upper abdominal trauma or any type of significant deceleration injury. In alert patients, chest pain will be a common complaint. Patients with cardiac contusion have been known to develop an angina-like pain, usually hours or days after the injury, and most often transient; when persistent, it must raise the suspicion of underlying coronary artery disease.[7] Pericardial irritation or true pericarditis can develop with typical pleuritic type chest pain.

This may be very difficult to interpret since chest pain from other injuries may be superimposed. Parmley noted that most patients with cardiac trauma have associated injuries; those involving the chest include rib and sternal fractures, pulmonary contusion, and hemopneumothorax.[7] The most common extrathoracic injuries occurring with cardiac contusion were cranial injuries, long-bone fractures, and splenic or hepatic damage.[18] Any of these easily could divert our attention away from the heart.

On physical examination, evidence of tamponade, a pericardial friction rub, a murmur or thrill (suggesting septal or valvular rupture), or evidence of congestive heart failure normally would alert one to a significant cardiac injury. However, with simple contusion, none of these may be present and external signs of thoracic trauma commonly a absent in this condition.

Can we rely on technology? Electrocardiograms (EKG) patients with myocardial contusion generally are abnorma but this obviously is not true in 100 percent of cases. Patien with known contusion have been found with normal EKG although in Parmley's series, he did not find any patien with autopsy-confirmed contusion and a normal EK before death.[7] The development of tachyarrhythmias an bradyarrhythmias in this setting, as well as conductio abnormalities, certainly should alert one to possible cardia trauma. The most common EKG change in contusion however, is nonspecific ST-T abnormalities.[8] One stud differentiated contusion from concussion by suggesting tha localized ST-T wave changes were more consistent with th former, whereas diffuse changes more often were seen wit the latter. However, for practical purposes, arrhythmias an conduction abnormalities were found in equal frequenc with contusion and concussion.[18] In open-chest dogs wit experimental direct cardiac trauma, mild injury (resulting i subendocardial contusion) caused ST segment depressior while more severe injury (with transmural involvement caused ST elevation.[11] Several authors point out that thes same nonspecific ST-T wave changes may result from tru myocardial ischemia, shock, hypoxia, electrolyte dis turbances, or cerebral injuries, and therefore are no diagnostic of cardiac trauma. We should think of the EKG then, as an indicator that is sensitive but not specific. It ma alert us to the possibility of cardiac injury, but it is no conclusive in allowing us to make a definitive diagnosis.

The cardiac enzymes (CPK or CPK-MB) should be con sidered. The MB band is known to be specific for myocardia damage. Patients with skeletal muscle trauma may have ar increased total CPK, but a negative MB. From myocardia infarction data, we can extrapolate that the degree of injur to myocardial cells is reflected in the quantity of CPK-ME and use this for contusions as well. In patients where MB wa used as a marker of contusion, it generally peaked within 2 hours and returned to normal in 72 hours. It must b remembered, however, that such external factors as hypoxia and hypotension markedly can prolong the duration of thi rise.[18] In a study of 220 patients with blunt chest trauma including 49 patients with suspected cardiac injury, 26 patients had elevated MB and presumed contusion; there was an 80 percent correlation when compared to their EKG criteria. In this same study, however, shock or severe hypox emia occurred in 6 of 26 patients whose MB test was positive and 4 of 23 patients with negative MB tests (23 versus 17 percent); there was a nearly equal incidence of rhythm and conduction abnormalities between the two groups (46 percent with contusion versus 56 percent with concussion).[18] Therefore, although MB positivity may be a marker for more severe cardiac injury, and possibly require more cautious management with respect to late sequelae, early complica tions, particularly arrhythmias (as well as serious associated injuries) occurred in both, and a negative CPK-MB does not appear to be a good reason not to observe and monitor someone.

What about cardiac scans? Most of the reports in the literature refer to technetium pyrophosphate. From animal experiments it is clear that technetium can accumulate in the contused myocardium as it does with a myocardial infarc tion; this abnormality may be demonstrable as early as two hours after injury. It appears as though at least 3 gm of myocardium must be injured in order to be visible by cardiac

sca.[20] Although proponents initially supported this method as an improved means of diagnosing contusion, and it generally is agreed that cardiac scans can help to localize an existing contusion, numerous reports of false positive scans (possibly due to overlying skeletal muscle trauma) as well as false negative scans in patients with documented injury attest to its lack of both sensitivity and specificity and have led to a lack of a willingness to rely on it as a screening diagnostic tool. Some of the false negatives may be because many contusions occur in the right ventricle, whose wall is so relatively thin that insufficient isotope can accumulate to be detectable.[25]

Although cardiac catheterization may be very helpful in diagnosing the existence and hemodynamic significance of a septal or valvular rupture, catheterization—particularly coronary angiography—is of no real value in diagnosing contusion. The pathology seems to involve the microvasculature and, except in those rare instances where there has been direct damage to coronary arteries, vessel involvement of the caliber that could be detected on angiography is not a part of this entity.[15]

Sutherland et al. used radionuclide angiography to study patients following blunt chest trauma and looked at both wall motion and hemodynamic effects. They found focal abnormalities of right and left ventricular wall motion in 17 of 25 patients, most of which resolved by the end of a 20-week followup. This suggests that these abnormalities (akinesis, dyskinesis, or hypokinesis) correlate with areas of contusion. They noted a marked preponderance of right ventricular abnormalities (12 of 17), with 3 of 17 being left ventricular. They also suggested that this may have had a significant effect on decreasing right ventricular function (as evidenced by an increased right ventricle end-diastolic volume and decreased right ventricle ejection fraction), and that this is secondarily could affect left ventricular function by its effect on preload.[20]

Pandian et al., using two-dimensional echocardiography studies on closed-chest dogs after blunt trauma, found an increase in end-diastolic wall thickness and an increase in echo brightness in the involved area of myocardium, with impaired regional systolic function.[21] This appears to be a promising noninvasive technique for diagnosing contusion soon after trauma. The ability of echocardiography to detect pericardial effusions (e.g. hemopericardium in this setting) already is well known.[22]

CONCLUSIONS

What conclusions can we draw from all this information that can be useful in taking care of these patients?

1. Since the diagnosis of myocardial contusion often is not made, it is impossible to determine the true prognosis; in most of these patients, the prognosis is related more to associated injuries than to the contusion itself. Because of this, and since such injuries are not always obvious in the hospital emergency department, patients with multiple injuries or those suspected of having isolated cardiac trauma based on the physical examination or mechanism of injury) should be admitted to a critical care unit. Patients with multiple trauma probably best are managed by a trauma team including general surgeons and cardiothoracic surgeons. Those with isolated chest trauma may be managed best primarily by cardiothoracic surgeons. Associated injuries should be treated by other appropriate specialists. Patients suspected of having myocardial contusion should not be denied requisite fluid replacement. However, caution should be exercised to avoid overhydration, since some of these patients will have depressed myocardial contractility, making them prone to congestive heart failure. Hemodynamic monitoring during such fluid administration therefore would be advisable.

2. Although a normal electrocardiogram (EKG) strongly suggests that no significant cardiac trauma has occurred, it is not absolute proof. Furthermore, such patients are at risk of arrhythmias, either from contusion or concussion to the heart or from associated hypoxia, shock, or other factors. Constant rhythm monitoring and serial EKGs are essential for all these patients. The most common EKG change associated with myocardial contusion is nonspecific ST-T wave abnormalities. This is a sensitive but not a specific diagnostic indicator.

3. The ultimate role of the other diagnostic laboratory aids mentioned previously is still unclear. Although such things as serum enzymes, cardiac scanning, and radionuclide angiography may help to confirm the severity or extent of cardiac damage, their utility in establishing a diagnosis of contusion is not yet well worked out.[23] It is clear, however, that they currently are not useful for making decisions at the level of the emergency department and should be reserved for these patients after they have been admitted to the hospital.

"Myocardial contusions, however, may occur with no external evidence of chest trauma, and little or no immediate hemodynamic consequences."

4. Patients generally should receive prophylactic treatment similar to those with myocardial infarction:[8] a) restriction of physical activity and continuous observation; a conservative approach would be to recommend two weeks of bed rest, probably correlating with the time during which the contused myocardium is most vulnerable; b) pain of cardiac origin may be relieved with mild analgesics, but narcotics occasionally are required; some clinicians suggest that oxygen is important for pain control—whether or not this is true, all such patients should receive supplemental oxygen to avoid hypoxia;[7] c) constant electrocardiogram (EKG) monitoring and serial EKGs should be performed; pressure monitoring, e.g. arterial pressure and pulmonary capilliary wedge pressure, may be indicated if there are significant hemodynamic abnormalities (hypotension or signs of congestive heart failure); and d) avoid anything which may increase myocardial irritability, e.g. hypoxia, electrolyte imbalance, arrhythmogenic drugs, and general anesthesia.

5. Treatment of complications, either immediate or delayed, include the following:

Arrhythmias: Use suppresive drugs or electrical conversion for tachyarrhythmias as one would do for a patient with myocardial infarction. There is nothing in the literature about prophylactic antiarrhythmics such as lidocaine, in this setting. Bradyarrhythmias, if they require treatment, probably best are treated by transvenous pacing.

Hypotension/pump failure: Since the integrity of noninjured myocardium may help to determine survival, maintaining arterial pressure is important in patients with decreased cardiac output. If fluid therapy or treatment with

positive inotropic agents is not adequate, the intraaortic balloon pump has been reported to be effective.[14]

Congestive heart failure: Should be treated as usual, with digitalis, diuretics, and vasodilators. Congestive failure often indicates a poor prognosis.

Anticoagulation: Despite the risk of systemic emboli from mural thrombus formation, most experienced clinicians recommend against the use of prophylactic heparin due to the danger of increased bleeding from other sites of trauma.[7]

Structural abnormalities: A number of structural abnormalities in the heart can occur as a result of cardiac trauma: they may be immediate or delayed, with or without primary contusion. These may require definitive surgery if they result in significant hemodynamic compromise, are not responsive to medical therapy, and/or develop so rapidly that the heart is unable to compensate. These include: 1) Ventricular aneurysm which may result in pump failure and be a source of persistent arrhythmias or emboli. 2) Myocardial rupture which may result in: a) exsanguination which usually is fatal and will be treatable only by immediate thoracotomy; a ruptured atrium may be controlled with a vascular clamp or a Foley catheter before being oversewn; bleeding from ventricular rupture may be slowed by digital compression and then closed using pledgeted sutures (cardiopulmonary bypass rarely is required);[24] and b) cardiac tamponade (suggested by hypotension, elevated CVP, pulsus paradoxus, distant heart sounds, and small amplitude QRS complexes on electrocardiogram) may be improved transiently and partially reversed by pericardiocentesis. However, if it recurs or if clotting occurs in the pericardial space and the clots cannot be aspirated through a needle, open chest surgical drainage may be necessary. 3) Septal rupture (especially ventricular septal defect) should be suspected when the patient develops a new murmur and—not uncommonly—a conduction defect following chest trauma, often coincident with the onset of congestive heart failure. Cardiac catheterization is the diagnostic test of choice. One looks for a stepup in oxygen saturation between the right atrium and ventricle, increased pulmonary artery pressure, and left-to-right shunt. A shunt of less than 1.5:1.0 often can be managed medically, with digitalis, diuretics, and afterload reduction.[25] This is preferable, since delaying surgical repair for at least six weeks has at least two advantages: it allows the patient to recover from associated injuries; and it allows fibrosis around the edges of the perforation which is better for secure suture placement. Emergency surgery for septal rupture with acute hemodynamic decompensation is associated with a high mortality rate and, in patients who survive, a significant incidence of recurrence due to separation of sutures originally placed in friable myocardium.[26] 4) Ruptured valve (including laceration or avulsion of a valve ring or leaflet, and ruptured papillary muscle and/or chordae tendinae)—the most common to be damaged is the aortic valve; the least common is the tricuspid.[7] Hemodynamic consequences will depend on the specific valve involved, as well as associated cardiac injuries. If decompensation is acute, valve replacement usually is the treatment of choice. As with septal rupture (with which it easily can be confused clinically), cardiac catheterization is the diagnostic test with the highest yield of information. 5) Constrictive pericard is the final and late complication of cardiac trauma. It become symptomatic weeks or months after the injury eventually require surgery with stripping of the pericard to restore hemodynamic integrity.

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Hypercalcemia Secondary to a Cervical Cancer: Resolution by Surgical Resection

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Hypercalcemia is a well-recognized complication of carcinoma. Extirpation or radiation of the malignant tissue of ovaries, lung, and other organs has been associated with return of calcium levels to normal. This case report documents resolution of hypercalcemia secondary to cervical cancer by near-total surgical resection.

Hypercalcemia has been reported as a complication of cancer of the cervix in nine cases.[1-3] Because of the large extent of the disease, successful treatment has been poor and normalization of the serum calcium level never has been documented. This case report documents, for the first time, normalization of calcium level following near-total surgical removal of a primary endocervical tumor.

CASE REPORT

A previously healthy 72-year-old white female was admitted to Englewood Hospital because of hypercalcemia.

She was treated in the last two years for mild hypertension with hydrochlorothiazide, but she discontinued her medication four months prior to admission. She had no other significant past medical history.

During the two months preceding her admission, she developed asthenia, anorexia, polyuria, polydipsia, nausea, intermittent abdominal pain, and constipation. She lost 11 pounds and became irritable and confused. No prior laboratory values were available.

On admission, her temperature was 98.8°F, blood pressure 174/80, and pulse 120. She weighed 174 pounds and her height was 5'4".

On examination she appeared pale, irritable, and confused. Her neck was normal without masses. Her lungs were clear. A grade III/VI systolic ejection murmur was heard at the apex and left sternal border. The breasts and abdominal examination were negative. No bone tenderness was elicited. Rectal examination revealed a large pelvic mass. Vaginal examination and visualization of the cervix were impossible because of severe vaginal atrophy. A blind Pap smear was sent for pathological examination.

On admission the hematocrit was 33.4 percent; the hemoglobin, 11.5 g/dl. The white cell count was 8,800 with 78% polymorphonuclear cells, 17% lymphocytes, and 5% monocytes. The urea nitrogen was 26 mg/dl (10-26); the creatinine, 1.1 mg/dl (0.6-1.4); the glucose, 108 mg/dl (85-125); the calcium, 15.8 mg/dl (8.5-10.5); the phosphorus, 2.4 mg/dl (2.5-4.5); and the magnesium, 1.0 mg/dl (1.5-2.4). The alkaline phosphatase was 120 IU (20-115); the uric acid, 9.4 mg/dl (2.5-7.7); the protein, 7.5 mg/dl (6.0-8.5); the albumin, 4.3 mg/dl (3.3-5.2); the sodium, 136 mg/dl (132-142); the potassium, 2.7 mg/dl (3.5-5.3); the chloride, 95

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mg/dl (94-106); and the carbon dioxide 29 mg/dl (25-32). The ESR was 85 mm. Thyroxine was 5.8 μg/dl (5.0-11.0); and the T3 R was 46% (35-45%). Blood samples were drawn for C-terminal PTH assay, 25-hydroxyvitamin D, and 1,25-dihydroxyvitamin D determinations.

A 24-hour specimen of urine showed 434 mg of creatinine, 238 mg of calcium, and 486 mg of phosphate.

X-rays of the chest and hands were within normal limits. Electrocardiogram showed nonspecific T wave changes.

Multiple medical treatments resulted in only a mild decrease in serum calcium level, so surgical exploration of the neck was performed. One normal parathyroid gland was removed and three others were visually normal. Postoperatively, the calcium remained elevated (between 11.5 and 13.9 mg/dl).

A CT scan of the mediastinum suggested a 1.5 cm lesion on the right side. A mediastinal exploration, however, failed to reveal any pathology.

The C-terminal PTH levels on admission and postoperatively were 1,680 and 1,360 pg/ml for a serum calcium level of 7.4 and 5.9 mEq/l (normal values: C-PTH: 430-1,860 pg/ml; calcium 4.5-5.2 mEq/l).* The 25-hydroxyvitamin D was 7 ng/ml (10-55), and the 1,25-hydroxyvitamin D 22 pg/ml (20-76 pg/ml).*

An intravenous pyelogram showed a mild dilatation of the left ureter and left renal pelvis. An ultrasound of the pelvis showed a fibroid uterus and a right ovarian cystic mass. A bone scan did not reveal any bone metastasis. The Pap smear showed dysplasia of squamous cells.

The patient underwent a pelvic exploration and bulk removal of a large endocervical cancer was performed. Both ovaries and the uterus, massively replaced with tumor, were removed. Lymphatic involvement was noted. The pathological diagnosis was that of an adenosquamous endocervical cancer with no involvement of the endometrium.

The patient had an uneventful postoperative course.

Postoperatively, the serum calcium level fell to normal within 24 hours. The C-terminal PTH level was 1,590 pg/ml for a calcium level of 4.1 mEq/l.

One month after resection of the primary tumor, the serum calcium was 8.6 mg per 100 ml without any medication.

DISCUSSION

Differentiation of hypercalcemia due to parathormone (PTH) elevation or nonparathormone causes usually is the first step in the evaluation of elevated serum calcium level. With increased or "inappropriately normal" PTH level, primary hyperparathyroidism is the likely diagnosis. However, ectopic PTH production also must be considered. In general, serum calcium levels are higher in patients with primary hyperparathyroidism. However, in 15 to 20 percent of hypercalcemic patients with both increased calcium and PTH levels, overlap occurs and the etiology of hypercalcemia is difficult to determine.[1-4] Recently, other biochemical measurements, especially 1,25-dihydroxyvitamin D level, have been suggested in helping to differentiate the causes of hypercalcemia. Increased 1,25-dihydroxyvitamin D levels seen in primary hyperparathyroidism while low to l normal levels are seen in other causes.[5]

Other suggested humoral causes of hypercalemia, usu seen with low-normal or suppressed PTH levels, oc secondary to malignancy and include prostaglandins, teolytic peptides, osteoclastic activating factor, and other

Our patient was incorrectly thought to have prim hyperparathyroidism and she underwent fruitless explo tion of the neck and mediastinum in search of an adeno Subsequently, she underwent a pelvic exploration and re tion of a metastatic cervical tumor. Remarkably, within hours, her calcium levels returned to normal.

Although other cases of surgical extirpation of canc (lung, ovary, and kidney) have resulted in normalizatior increased calcium levels,[7,8] this is the first documentation its occurrence with an endocervical tumor.

Whether the humoral substance produced by this patie tumor was PTH or a PTH-like substance is under investi tion.

The low-normal 1,25-dihydroxyvitamin D level in t patient was consistent with a nonparathyroid cause hypercalcemia. In the future, this test may be a use screening test for differentiating humoral hypercalcemia malignancy from primary parathyroid hormone excess.[5]

SUMMARY

We report a case of hypercalcemia secondary to a cervi cancer. Differentiation of hypercalcemia by parathyr hormone assay did not define the etiology of the eleva calcium level. The "inappropriate normal" C-PTH termination along with the elevated calcium level sugges primary hyperparathyroidism. However, a fruitless seat for adenoma was undertaken.

The low-normal 1,25-dihydroxyvitamin D level has be suggested in helping to differentiate humoral hypercalcen of malignancy from that of primary parathyroid hormo excess.

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Traumatic Rupture of the Abdominal Wall Without Evisceration

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Ve operated on 2 cases of traumatic hernia of the abdominal wall. rom the data pool constructed of the 14 cases since 1964, the echanism of injury is established, the associated injuries are abulated, and the surgical implications of this injury are discussed.

Although spontaneous rupture of the rectus abdominal muscle is fairly common, herniation through a traumatic rent in the abdominal wall rarely is reported.[1] Flain published a case report in 1964 and, at that time, ncluded 16 cases from the world literature as reported by 11 uthors.[2] Review of the literature since 1964 reveals 11 dditional cases. Recently, 2 cases have been seen and perated on at Saint Barnabas Medical Center, Livingston. he purpose of this report is to review the mechanism of njury and the management of this rather rare problem.

CASE REPORT #1

A 35-year-old white male admitted to Saint Barnabas Medical Center on April 27, 1982, was struck on the driver's ide of his car by the branch of a large tree, which fell on his noving vehicle. Physical examination revealed signs of internal bleeding and abdominal distention. There was a large contusion and skin abrasion over the left upper quadrant at he level of the lower costal margin with obvious traumatic disruption of the muscles beneath and reducible hernia beneath the intact skin. He complained of pain in the left shoulder. His vital signs were stable, but peritoneal lavage showed gross blood. At operation, a midline incision exposed multiple perforations of the proximal jejunum. The transverse colon mesentery was disrupted, and a portion of the left transverse colon was found to be ischemic with torn serosa. There was no fecal contamination from the colonic injury.

The segment of injured small bowel was resected and a primary anastomosis carried out. Bleeding from the transverse mesocolon was controlled, the ischemic colon was resected, and a divided proximal colostomy was done. The rupture of the abdominal wall was repaired easily from within. Large, interrupted, nonabsorbable sutures through the defect in the peritoneum and transversus abdominal muscles were taken. These deep-placed sutures, that did not grab subcutaneous tissue from within, repaired the hernia in a single row. Viable, contused skin was left intact and no separate repair was made anatomically of the external oblique fascia. The incision was closed primarily without drainage. The patient did well and returned nine weeks later for colostomy closure, which was uneventful. At the time of this closure, the contused, abraded skin had healed completely without necrosis, and there was no evidence of hernia at the site of repair of the abdominal wall.

CASE REPORT #2

A 43-year-old white male concrete worker was admitted to Saint Barnabas Medical Center on May 21, 1982. He had fallen into a ten-foot excavation, impaling his left side on a steel reinforcement rod. His vital signs were stable on admission, and his only obvious injuries were a stellate laceration of the left arm and a large abrasion of the left upper quadrant. Prompted by the passage of a nasogastric tube, a Valsalva maneuver produced a bulge in the abdominal wall at the abrasion site. Crepitus then was noted in the subcutaneous tissues of the left flank, but the chest x-ray was negative. The urine, which initially had been clear, became bloody, and an intravenous pyelogram demonstrated

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TABLE

Patient Characteristics

Author	Patient	Mechanism of Injury and Physical Findings	Associated Injuries	Repair of Hernia
Atiempo	6M	Cow's horn—LLQ rent.	None	6 days
Clain	48M	Handlebars—L groin bulge.	Minor bruises	1 week, stainless steel lattice
DuBois	49M	Handlebars—RUQ bulge; R flank crepitus (thought to be hematoma).	R hemothorax with 12th rib fracture	12 days, Prolene
Fredlund	16F	Auto headlight—epigastic bulge (thought to be hematoma).	Small-bowel perforation; concussion; peripheral nerve plexus injury	Same day, Mersilene
Hurwitt	26F	Seatbelt—ecchymosis of abdominal wall (hernia did not present until months later).	Concussion; facial fractures; L_4-L_5 subluxation	16 months, wire
Jamieson	42M	Pushing heavy container—L pararectal hernia.	None	
Kaude	16F	Auto headlight—hematoma of abdominal wall and subcutaneous crepitus.	Small bowel perforation	Same day
Martinez	56F	Auto accident—no abdominal findings (hernia did not present until months later).	Face, shoulder, rib, and angle fractures	6 months, Marlex
Maunola	19M	Handlebars—lump R groin.	None	Same day, sutured in layers
	9F	Handlebars—lower abdominal lump.	None	Chromic
Moses	58F	Fall over bedpost; protrusion LLQ.	Small bowel obstruction	10 days, wire
Roberts	9M	Handlebars—lump LLQ.	None	Same day, 00 chromic
Astarita	35M	Falling tree limb—abrasion; hernia LUQ.	Small bowel perforation; transverse colon ischemia	Same day
Astarita	42M	Impaled on steel rod in fall—abrasion; hernia LUQ.	Transverse colon injury; splenichilar disruption; shattered upper pole (L) kidney	Delayed

two functioning kidneys without obvious injury. Peritoneal lavage revealed gross blood so the patient was taken to the operating room. Operative findings included near transsection of the transverse colon. The upper pole of the left kidney was shattered and there was a small hilar injury to the spleen. Resection of the colon with colostomy, partial nephrectomy, and splenectomy were performed. The left arm wound was debrided. The repair of the abdominal wall, in this case, was not carried out at the time of the original injury and was deferred until subsequent colostomy closure.

DISCUSSION

Maunola stated, "The abdominal wall is a good shield against blunt trauma, but the protected organs may be damaged more often than the shield itself."[10]

In dealing with nonpenetrating injuries to the abdominal wall, with or without associated trauma to the internal organs, it becomes evident that the mechanism of injury is of paramount importance. The handlebars of a snowmobile or bicycle, the horn of a cow, the headlight of an automobile, or the seatbelt worn by a driver all share the characteristic of transmitting extensive forces in a focal manner to the abdominal wall. The characteristics of the patients reported in the literature, including our own cases, are included in the Table. The following discussion centers around this series of patients in terms of their initial presentation, associated injuries, and the timing of the operation.

Only one patient initially appeared to be in shock and this can be related to very extensive injury.[5] All others, surprisingly, had very stable vital signs at the time of admission although some may have deteriorated if they had been followed longer. The hernias of three of the patients were first thought to be hematomas;[3,4,7] in one patient, the diagnosis was not suspected until the supposedly infected hematoma was incised, demonstrating the subcutaneous position of the bowel.[3] Subcutaneous crepitus previously was described twice and was present in one of our cases. One patient, a 49-year-old who struck his right upper quadrant against the handlebars of a snowmobile, had crepitus related to an associated hemothorax with fracture of the right 12th rib rather than to disrupted bowel.[3] A 16-year-old girl was struck by the headlight of an automobile and developed epigastric crepitus along with findings suggestive of internal injuries. Her epigastric finding was related to three small-bowel perforations.[7] Both of our patients had bowel injuries and one demonstrated associated crepitus.

There were no associated injuries in five cases, but other findings were: small bowel perforation, concussion, periph-

al nerve injuries;[4] facial fractures and subluxation of L_4 L_5;[5] facial, rib, shoulder, and ankle fractures;[9] and small-bowel obstruction.[11] One of our patients had injuries to the kidney and spleen, in addition to a disruption of the transverse colon.

The patient with small bowel obstruction presented an interesting treatment problem. This 58-year-old woman apparently was addicted to drugs and alcohol, and 10 days prior to her hospitalization for an incarcerated hernia in the left lower quadrant, she fell over a bed and struck the bedpost with her lower abdomen. Hernia repair, in that case, involved reinsertion of the rectus sheath and peritoneum into the pubis with wire sutures. Among the remaining patients, five had the hernia repairs on the day of injury,[4,7,10,12,13] two within one week of injury,[12] and one 12 days later.[3] The only patient who required Marlex came to repair 6 months after the injury.[9] The longest interval from injury to repair was 16 months, and this repair was done with wire sutures.[5]

Abdominal wall disruption can occur when a tremendous force is applied to the abdominal wall over a rather small surface area as with an impaling type of injury by a bedpost, the horn of a cow, or the limb of a falling tree. The forces can be so great they can be transmitted through the abdominal musculature. The combination of forces, plus the elasticity of the skin, allows the impaling implement actually to be driven a considerable way into the peritoneal cavity without disruption of the skin, thereby transmitting the force to the internal organs and creating injury. With cessation of the force and withdrawal of the implement, the skin remains intact, although it may be abraded and contused by the stretching forces.

In reviewing our cases and those in the literature, it appears that 5 of 14 patients (36 percent) developed significant intraabdominal injuries so that immediate surgical intervention was necessary. It would appear, then, that patients who have blunt injuries to the abdominal wall, producing traumatic rupture with herniation, should be considered prime candidates for associated intraabdominal pathology. Abrasions and contusions on the abdominal wall should suggest to the examining physician that this may be the case. If the physical findings are not obvious, peritoneal lavage may be diagnostic.

Since the results with primary repair of these hernias are good and the incidence of associated intraabdominal pathology is high, these patients should be considered for exploratory laparotomy and concomitant hernia repair at the time of their injury.

CONCLUSIONS

Two additional cases presenting with blunt trauma to the abdominal wall and traumatic rupture and herniation without disruption of the skin are added to the 28 cases reported in the literature. The mechanism of these and associated injuries and their management have been reviewed. The high incidence of intraabdominal pathology should alert one to the potential need for exploratory laparotomy. Immediate repair is recommended when the diagnosis is confirmed.

SUMMARY

Traumatic hernia of the abdominal wall is the result of blunt trauma which generally is due to an impaling type of injury. A study of the 14 patients since 1964 by various authors reveals a 36 percent incidence of significant intraabdominal injuries mandating timely surgical intervention. Intestinal perforation was the most commonly encountered injury and was present in 4 of the 5 patients who underwent immediate surgical exploration. One of these patients also had a ruptured spleen and lacerated kidney. The fifth patient developed a small bowel obstruction from incarceration within the traumatic hernia.

It is concluded that patients who have developed traumatic rupture of the abdominal wall as a result of an impaling type of blunt injury have had major trauma with a high likelihood of intraperitoneal injury from the impaling object, even if the skin remains intact. Abdominal exploration and repair of the hernia should be carried out promptly if the diagnosis is made at the time of the injury.

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Addison's Disease Presenting in the Postpartum State

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HUSSEIN ABOUL-HOSN, M.D., ROBERT NUTT, M.D., Englewood*

Postpartum adrenocortical insufficiency is an uncommon event which usually is related to vascular insufficiency leading to pituitary ACTH deficiency (Sheehan's syndrome). In contrast, we describe a very rare case of postpartum primary adrenocortical insufficiency (Addison's disease) and contrast it with Sheehan's syndrome.

Postpartum adrenocortical insufficiency usually is seen as a complication of intrapartum or postpartum hemorrhage. This condition, known as Sheehan's syndrome, occurs secondary to pituitary ACTH deficiency and appears in approximately 1 per 10,000 deliveries.[1] It is characterized, in part, by hypotension, electrolyte disturbances, and amenorrhea.[1,2]

In contrast, we report a patient with primary adrenocortical insufficiency (Addison's disease) who presented similarly in the postpartum state but whose additional physical findings and laboratory data distinguished these two very uncommon conditions. We believe this is the first such case report.

CASE REPORT

Approximately six weeks postpartum, a 21-year-old white female complained of weakness, anorexia, and dizziness, which were first noted during her fifth month of pregnancy. The pregnancy was otherwise uneventful, and a healthy 6-lb, 5½-oz female child was delivered without any major hemorrhagic episode. The newborn was nursed by her mother for approximately two weeks and this was stopped voluntarily.

Except for vitamin and iron supplements, the patient did not take any medications while pregnant. Postpartum, she was treated with ampicillin for a urinary tract infection.

Blood pressure was 80/56 mm Hg supine and 75/50 mm Hg erect. Physical examination disclosed hyperpigmented skin between the hand creases as well as the nipples, genitalia, and anal regions. Few small hyperpigmented areas also were noted on her tongue and gingiva. No signs of skin infection were seen. A small amount of milk could b expressed from her breasts. The rest of the physical examina tion essentially was negative except for minimal scalp hai loss.

Significant laboratory data were a low sodium of 13 (135 to 148 mEq/1), a high-normal potassium of 5.3 (3.5 to 5. mEq/1), and an absolute lymphocytosis. Thyroid functio tests showed a normal total T4 and T3 R.U. but an elevate TSH of 13 (normal: <7 μIU/nl).

Several a.m. cortisol levels were in the range of 1 to 2 mcg/d (normal: 10 to 25 mcg/dl); after admission of ACTH cortiso values were 1 and 2 mcg/dl. Admission ACTH level wa elevated to 315 (normal: < 80 pg/nl). Prolactin was elevate to 81 (normal: 6 to 22 ng/ml) and LH and FSH were withir normal limits. Aldosterone level was 4 (normal: 4 to 3 ng/dl) measured when the sodium was below normal. An tithyroglobulin and antithyroid microsomal were negative. Antiadrenal antibodies were positive. The patient wa treated with cortisone acetate, fludrocortisone acetate (Florinef®), and levothyroxine sodium (Synthroid®), and showed a marked improvement of her initial symptom within 48 hours.

DISCUSSION

Adrenocortical insufficiency conveniently is divided into primary and secondary causes. In the postpartum state this condition almost always has been related to ACTH failure as

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a result of vascular insult to the pituitary gland. Other trophic hormones usually are simultaneously diminished.[2] As a consequence of these hormonal deficiencies, amenorrhea, asthenia, hypotension, and electrolyte disturbances commonly are seen.

"Pigmentation of skin creases and on the buccal mucosa is characteristic of Addison's disease and may be related to elevated ACTH levels (or its peptide fragments)."

Primary adrenal failure also can present a similar clinical picture. However, in contrast, the Addisonian picture as illustrated by this patient demonstrates essential differences. First, is the ability to lactate. Sheehan's syndrome often is suggested solely by the inability to breastfeed due to low prolactin and estrogen levels. In contrast, our patient had galactorrhea six weeks postpartum and an appropriately elevated prolactin level was recorded. Secondly, although normal pigmentation of the areola of the nipples, a linea nigra and chloasma may appear in Sheehan's patients, pigmentation in skin creases and on the buccal mucosa is characteristic of Addison's disease and may be related, as in this patient, to elevated ACTH levels (or its peptide fragments).[3]

Finally, although hyponatremia may appear in either primary or secondary adrenal failure, a distinctly high-normal or elevated potassium level is frequent only in the former condition, reflecting the inappropriate low mineralocorticoid level, as seen in this patient.[4,5]

The positive antiadrenal antibodies found in this patient (and negative tuberculosis skin test) suggest the autoimmune nature of her disease and a family evaluation is planned.

The early thyroidal failure, demonstrated by the elevated TSH level, points to a polyglandular disease in this patient (Schmidt's syndrome). She will be followed carefully for signs of other endocrine organ dysfunction.[6] It should be emphasized, however, that recent evidence suggests that high TSH levels in untreated adrenal insufficiency may be an unreliable index of thyroid failure since these levels may return to normal following standard maintenance cortisone therapy.[7]

SUMMARY

A case of primary adrenal insufficiency (Addison's disease) in the postpartum state is described and contrasted with Sheehan's syndrome. The ability to lactate, pigmentation in specific locations (i.e. creases, buccal mucosa), and relative hyperkalemia are early clues to distinguish an Addisonian picture. Ultimately, an elevated ACTH level with a low cortisol measurement confirmed the diagnosis.

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Amyloidosis: A Perspective

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We cared for a woman with biopsy-proved amyloidosis. Her illness also had features of multiple myeloma. Her disease illustrates the overlap between three groups of conditions: β-fibrilloses, monoclonal gammopathies, and B-lymphocyte malignancies. Recent advances in biochemistry and immunology permit a clearer understanding of the interplay among these conditions.

A patient had features of multiple myeloma and amyloidosis. The question arose whether she had two separate disorders or one condition "secondary" to the other. Recent immunological and biochemical studies suggest the patient had only one disorder, which may have various clinical manifestations. Our discussion will suggest she had a lymphocyte malignancy associated with a monoclonal protein, and that this particular protein had the properties necessary to aggregate in the form of amyloid.

CASE REPORT

A 58-year-old white female was admitted to Saint Barnabas Medical Center, Livingston, because of fatigue for one year. Past medical history revealed that an enlarged liver incidentally had been noted during cholecystectomy three years earlier. She had insulin-dependent diabetes mellitus for two years. Physical examination revealed a blood pressure of 160/90 and hepatomegaly to 15 cm below the right costal margin. There were no splenomegaly, abdominal masses, adenopathy, bony tenderness, or enlargement of the tongue.

Laboratory results revealed: hemoglobin, 11.5 g/dl; WBC, 14,300/mm³ with 4 percent plasmacytoid lymphocytes; platelets, 329,000/mm³; sedimentation rate, 67 mm/h; blood urea nitrogen, 68 mg/dl; creatinine clearance, 12 cc/minute; albumin 3.6 gm/dl; globulin, 4.0 gm/dl; glucose, 220 mg/dl; prothrombin and partial thromboplastin times were normal. Direct Coombs' was positive with IgG and complement noted on the red cells.

A liver biopsy was performed without complications and revealed extensive amyloid deposition. Bone marrow aspiration showed 18 percent lymphocytes and 8 percent plasma cells. Serum protein electrophoresis indicated an IgG (κ) spike. Total IgG was elevated to 2,340 mg/dl. IgA level was normal and the IgM level was low. The urine contained both free κ chains as well as intact IgG (κ) molecules. The kidneys were normal size by ultrasonography.

The patient received two monthly courses of prednisone and melphalan with a resulting 20 percent fall in the IgG level. However, renal dialysis became necessary to control congestive heart failure. Terminally, she developed increasing hepatic failure and died in coma. Permission for autopsy was denied.

AMYLOID

"Amyloid" refers to amorphous material deposited in extracellular tissues. It is identified by certain photic and tinctorial characteristics that result from the unusual structure of amyloid.[1] All amyloid deposits examined consist of rigid, nonbranching fibrils[2] which are arranged in a twisted β-pleated configuration.[3] The β-pleated sheet is the most thermodynamically stable, three-dimensional arrangement in vivo for certain polypeptide chains. The amino acids which constitute the polypeptides are arranged in long parallel fibrils, each of which is twisted like a ribbon. Every other fibril is twisted in the same direction.[4] The parallel fibrils, when layered side by side and on top of each other, create a mass having breadth and depth.

Several different groups of proteins clearly have been shown to be capable of aggregating as amyloid. Some immunoglobulins, particularly fragments of their light chain

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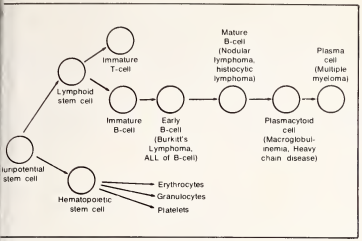


Figure 1—Scheme of B-cell lymphocyte differentiation and relationship to some lymphocytic malignancies.

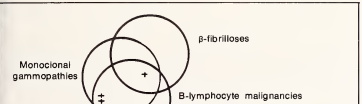


Figure 2—Diagram of the interrelationships of three groups of conditions; † represents our patient; ‡ represents C. L. L. with IgM.

components, have this capacity.[5] It has not been possible to identify specific characteristics which impart "amyloidogenicity" to certain light chains.[6] Immunoglobulin is the basis for the so-called "primary" type of amyloid; as well as for the myloid associated with multiple myeloma, monoclonal gammopathy, Waldenström's macroglobulinemia, and lymphomas.

Amyloid formation not only requires a protein with intrinsic "amyloidogenic" properties, but probably involves modification of a precursor protein by proteolysis. This double requirement would help explain why amyloidosis is found in only a small percentage of patients having a suitable precursor protein.[7] Thus, amyloidosis is not a single disease entity. Rather, it is the final common pathway for several different proteins in a variety of clinical conditions. Since all amyloid form β-pleated sheets, the generic term "β-fibrilloses" appears most appropriate.[8]

MONOCLONAL GAMMOPATHIES

Monoclonal gammopathy refers to an excess production of immunoglobulins in which all molecules have completely identical amino acid composition of their heavy and/or light chains. The homology of proteins of a monoclonal gammopathy strongly suggests that the producing plasma cells originated from a common precursor cell; a group of cells so derived is called a clone.[9]

For clinical purposes, monoclonal gammopathy frequently is split into six subgroupings: multiple myeloma; macroglobulinemia of Waldenström; benign monoclonal gammopathy; immunoglobulin associated with other diseases such as sarcoid, tumors, and hyperparathyroidism; heavy chain disease; and amyloidosis. The clinical manifestations partly reflect the intrinsic properties of the particular immunoglobulin involved. For example, free light chains play a major role in the renal failure of myeloma.[10] The high molecular weight and intravascular location of IgM leads to the hyperviscosity of macroglobulinemia.

These six subgroupings represent an artificial classification that does not satisfy all situations. Many cases of benign monoclonal gammopathy actually evolve into frank myeloma.[11] Amyloid not always is separate from the other subgroupings, as it has been reported to occur in about 10 percent of patients with myeloma[12] and it also had been reported with macroglobulinemia[13] and with heavy chain disease.[14] Therefore, the generic term "monoclonal gammopathy" expresses the common abnormality of all these subgroupings.

B-LYMPHOCYTE MALIGNANCIES

There exists a pluripotential stem cell with the capability for self-renewal and the ability to divert its daughter cells into either the lymphocytic or hematopoietic series. (The existence of human stem cells has been proved only indirectly.) The first cell of the lymphoid series also is a stem cell, which has the capability to divide and differentiate into either the B-cell or the T-cell line.[15] Those lymphocytes requiring some exposure to the thymus for proper development are called T-cells, or T-lymphocytes. Those requiring exposure to the bone marrow analogously are called B-cells, or B-lymphocytes (Figure 1).

Once committed to the B-cell line, a particular cell will mature through several steps, some of which can be identified by the presence of a combination of specific membrane antigens and cytoplasmic and membrane immunoglobulins. A particular cell also will undergo changes in size during this maturation process and may remain in the different stages for variable durations.[16]

The small B-lymphocyte matures into a plasma cell, which is a true end-stage cell. Plasma cells, including neoplastic ones, probably do not divide routinely to produce more viable plasma cells. Additional plasma cells may be recruited from cells "resting" further back in the B-cell line. Indirect evidence for such recruitment comes from studies of normal looking small lymphocytes which have been identified as part of the neoplastic clone of multiple myeloma.[17]

Each of the malignant cells that accumulates to excess in a B-lymphocyte malignancy is antigenically identical to all the others. Although this implies clonality of origin, the cells all may not look identical for they may be in slightly different stages of maturation.[18] Even the large mononuclear cells historically called "histiocytes" or "reticulum cells" have been identified by surface marker studies as B-lymphocytes which have undergone maturation into plasmacytoid cells. The true histiocyte is a progeny of the monocyte-macrophage cell line. Malignancies of the true histiocyte do occur, but they are much less common than lymphocyte malignancies.[9,19]

Nonetheless, the majority of the clonal cells frequently reflect one particular stage of the normal development sequence. For example, as shown in Figure 1, Burkitt's lymphoma cells can be related to an early B-cell stage through surface antigen studies. Similarly, the malignant cells in both Waldenström's macroglobulinemia and heavy chain disease resemble the near end-stage cell, the plasmacytoid cell. The malignant cells also may retain some of the biological properties of their normal B-lymphocyte counterpart. Thus, it is not unusual to find circulating malignant lymphocytes in a patient with nodular lymphoma. Immunoglobulin may be produced by the malignant cells in

macroglobulinemia, heavy chain disease, or multiple myeloma.

The histology of a particular patient's B-lymphocyte malignancy may change over time. Examples of this include: lymphocytic lymphoma, well-differentiated yielding lymphocytic lymphoma, poorly differentiated on repeat biopsy;[20] histiocytic lymphoma developing in a patient with prior chronic lymphocytic leukemia[21] or multiple myeloma;[22] and Waldenström's macroglobulinemia terminating in immunoblastic sarcoma.[23] These cases do not represent the development of a second, unrelated malignancy. Rather, they are a second expression of the same clone of malignant B-lymphocytes. This can be shown by the presence of identical surface antigens and immunoglobulins on the cells obtained at first and subsequent biopsies.

CONCLUSION

The three groups of conditions discussed; β-fibrilloses, monoclonal gammopathies, and B-lymphocyte malignancies can be visualized as three intersecting circles. Our patient would lie at the intersection of all three circles since her disease involved all these conditions. (Figure 2). Another example is the IgM monoclonal spike which may accompany typical chronic lymphocytic leukemia involving B-lymphocytes.[24] Here the disease would lie at the intersection of two circles (Figure 2).

Through an understanding of the biological behavior of the cells and the proteins involved, it is possible to pinpoint on this diagram many such patients who appear to have one or more of these conditions.

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CLINICAL NOTE

Mixed Substance Abuse Withdrawal Treated by Clonidine

LAN F. JAVEL, M.D., Newark*

reatment of mixed substance withdrawal involves precise doses nd abusable drugs. Clonidine was administered to a codeine nd glutethimide abuser to treat withdrawal symptoms. The result as consistent with the postulated nonspecific action of clonidine n the withdrawal syndrome. Clonidine holds promise for treating ich withdrawal.

Mixed or multiple substance abuse is a syndrome that has remained problematic since the recognition of its creasing incidence approximately ten years ago.[3] The inner ty is not the only location of the problem; higher socieconomic classes often are affected, in part due to greater vailability of pills. One difficult aspect of the problem volves treatment of withdrawal symptoms. For abuse of a ombination of often unknown amounts of addictive subances, a similar combination of licit substances may need to e administered. The dosages of such medications are based n clinical evaluation and observations, occasionally not ithout a measure of guesswork based partly on unreliable eports by the addict.

Within the last five years the use of clonidine** to treat piate withdrawal has been investigated; the major work eing done at Fair Oaks Hospital, Summit.[1] The mechanism f action is postulated as an inhibition in the locus coeruleus rough alpha-2 adrenergic receptors, a seemingly more onspecific action than similar inhibition through opiate eceptors in the same area.[2] If such a mechanism were indeed less specific means of treating opiate withdrawal, then one ight treat other types of withdrawal with clonidine. The ollowing case gives support to this hypothesis.

CASE REPORT

A 33-year-old white male college dropout applied for outpatient services at the University Hospital Community Mental Health Center. He complained of a two-day history of insomnia, tremulousness, sweating, stomach cramps, diarrhea, and drug craving. He claimed to have been abusing glutethimide*** and codeine on and off for approximately 17 years, with recent daily use of over five pills of each for at least 1 year. He stopped the day before and tried to manage his withdrawal symptoms (unsuccessfully) with diazepam.**** He was noted to have gooseflesh, anxiety, and tremulousness. His blood pressure was 120/80 sitting and 120/82 standing. After explaining the side effects and the experimental nature of clonidine as used for withdrawal, we prescribed clonidine 0.1 mg twice per day.

When seen for followup three days later, he was not

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**Clonidine: Catapres®.

***Glutethimide: Doriden®.

****Diazepam: Valium®.

abusing pills. He generally felt tired with some dizziness on postural change but free of shakiness, sweating, cramps, and drug craving. Blood pressure was 102/62 sitting and 94/62 standing. Clonidine was continued for another four days. The patient did not report the return of withdrawal symptoms, so clonidine was discontinued.

DISCUSSION

Although not officially approved for treating withdrawal, clonidine shows great promise for such an application.

Originally intended to treat this patient's withdrawal symptoms from codeine, clonidine seems to have covered all withdrawal symptoms including any from glutethimide withdrawal. The dose was within the recommended 0.1 to 0.2 mg twice per day range. The treatment was superior to diazepam in this case. The results are consistent with an action on a nonspecific locus or final common pathway o withdrawal symptoms. Clonidine generally is safe, wit manageable side effects of dry mouth, drowsiness, sedation constipation, and dizziness. Doctors and many patient would appreciate its nonnarcotic and nonaddictive nature. I further use shows good results, then treating mixed substanc abuse withdrawal, especially on an outpatient basis, could b done with such a medicine with a welcome low potential fo abuse.

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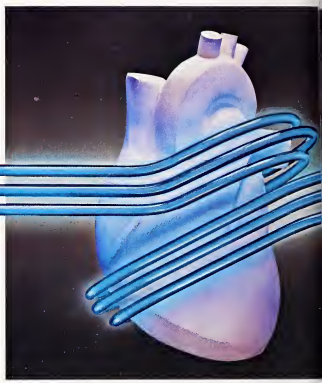
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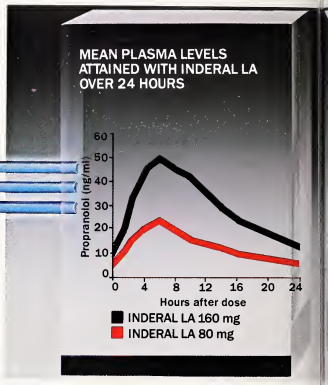
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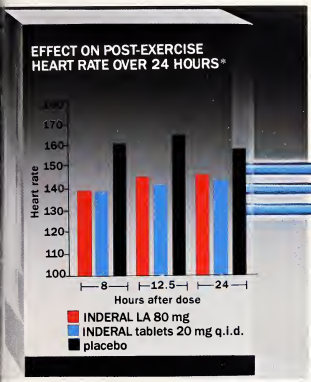
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In placebo-controlled trials, INDERAL LA was found to provide sustained 24-hour beta blockade as measured by decrease in heart rate, systolic blood pressure, and rate-pressure product. Patients taking once-daily INDERAL LA receive continuous protection from dose to dose—with therapeutic response equivalent to multiple daily doses of INDERAL tablets.

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of INDERAL LA capsules is a trademark of Ayerst Laboratories.

*INDERAL LA vs. tablets: N.S. at all hours measured.
*INDERAL LA vs. placebo: $p<.05$ at all hours measured.

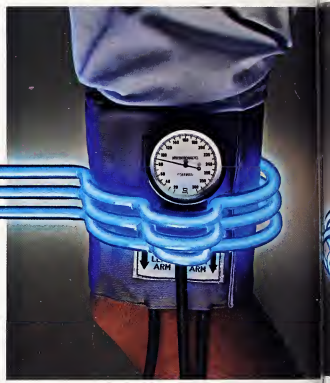
Please see last page for Brief Summary of Prescribing Information.

NEW

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



THE ONE TO COUNT ON FOR INITIAL THERAPY IN HYPERTENSION

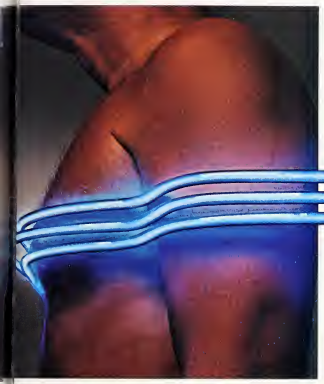
Start with 80 mg once daily

The usual initial dose is 80 mg INDERAL LA whether used alone or with a diuretic. Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control.

When converting patients from other beta blockers including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary.

Unsurpassed convenience and simplicity

Enhanced patient compliance



THE ONE TO COUNT ON

AND ANGINA

Simplified core therapy begins with 80 mg once daily

Although individual patients may respond to various doses, the average optimal dose in angina pectoris is 160 mg once daily.

Compatible with other conventional antianginal therapies

The experience and protection of INDERAL

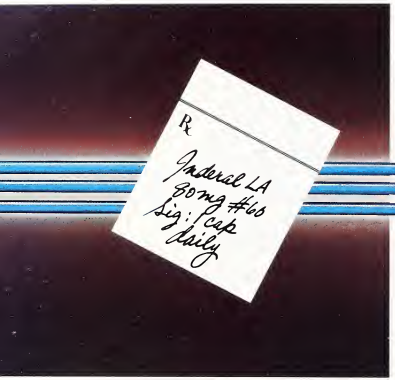
Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of INDERAL LA capsules is a trademark of Ayerst Laboratories.

Please see last page for Brief Summary of Prescribing Information.



THE ONE™ TO COUNT ON

THE ONE TO COUNT ON FOR THE EXPERIENCE OF INDERAL NOW WITH ONCE-DAILY DOSAGE

In hypertension, angina, and migraine—start with 80 mg once daily

Smooth 24-hour control

Unsurpassed simplicity and convenience

Enhanced patient compliance

Three strengths for prescribing convenience

For arrhythmias, use conventional INDERAL® tablets

Ayerst®
AYERST LABORATORIES
New York, N.Y. 10017

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ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES

ONCE-DAILY
INDERAL®
(PROPRANOLOL HCl)

LONG ACTING CAPSULES



F SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

IERAL® LA brand of propranolol hydrochloride
Capsules (80 mg, 120 mg, 160 mg Long Acting Capsules)

CRIPTION. Inderal LA is formulated to provide a sustained release of propranolol ochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

ICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocker- gent possessing no other autonomic nervous system activity. It specifically competes eta-adrenergic receptor stimulating agents for available receptor sites. When access to receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator ases to beta-adrenergic stimulation are decreased proportionately.

NDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled predictable rate. Peak blood levels following dosing with INDERAL LA occur at about urs and the apparent plasma half-life is about 10 hours. When measured at steady state a 24-hour period the areas under the propranolol plasma concentration-time curve s) for the capsules are approximately 60% to 65% of the AUCs for a comparable ad daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater tic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) s then decline exponentially.

NDERAL LA should not be considered a simple mg for mg substitute for conventional ranolol and the blood levels achieved do not match (are lower than) those of two to four rly dosing with the same dose. When changing to INDERAL LA from conventional ranolol, a possible need for retitration upwards should be considered especially to tain effectiveness at the end of the dosing interval. In most clinical settings, however, ay hypertension or angina where there is little correlation between plasma levels and al effect, INDERAL LA has been therapeutically equivalent to the same mg dose of entional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour ise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA provide effective blockade for the 24 hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. ng the factors that may be involved in contributing to the antihypertensive action are reduced cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminu- of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total herral resistance may increase initially, it readjusts to or below the pretreatment level with ual use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL en shown to cause a small increase in serum potassium concentration when used in atment of hypertensive patients.

ong anginal pectoris, propranolol generally reduces the oxygen requirement of the heart y given level of effort by blocking the catecholamine-induced increases in the heart rate, olic blood pressure, and the velocity and extent of myocardial contraction. Propranolol ently increases the oxygen supply to ischemic heart muscle by shifting the blood- and diatolic sure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade ually advantageous and is manifested during exercise by delayed onset of pain and ased exercise ability.

in dosages greater than required for beta-blockade, INDERAL also exerts a quinidine- or anesthetic-like membrane action which affects the cardiac action potential. The icance of this membrane action in the therapeutic effects of propranolol is unclear.

The mechanism of the antimigraine effect of propranolol has not been established. adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in combating vertigo of central labyrinthologic or ibular origin, sympathetic activity is detrimental to the patient But there are also itions in which sympathetic stimulation is vital. For example, in patients with severely aged hearts, adequate ventricular function may depend entirely on sympathetic drive ing heart rate. In the presence of AV block, greater than first degree, beta kade may prevent the necessary facilitating effect of sympathetic activity on conduction. blockade results in bronchial constriction by interfering with adrenergic bronchodilator ary which should be preserved in patients subject to bronchospasm

Propranolol is not significantly dialyzable

ICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the manage- hypertension, it may be used alone or used in combination with other antihypertensive nts, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of ertensive emergencies.

Angina Pectoris due to Coronary Atherosclerosis: INDERAL LA is indicated for long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache efficacy of propranolol in the treatment of a migraine attack that has started has not been ablished and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of ptomatic subaortic stenosis, especially for those patients who cannot undergo surgery other definitive measures.

opha, palpitations, and syncope. INDERAL LA also improves exercise performance. The ctiveness of propranolol hydrochloride in this disease appears to be due to a reduction of elevated rate of tension development which is exacerbated by beta-receptor stimulation. inal improvement may be temporary.

NTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree heart block; 3) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable INDERAL.

RNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component aining circulatory function in patients with congestive heart failure, and its inhibition by a blockade may precipitate more severe failure. Although beta blockers should be ided in overt congestive heart failure, if necessary they can be used with close follow-up provide medical support. If failure who are being digitalized and are receiving digitalis and retics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on rt muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta ckers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of art failure, the patient should be digitalized and/or treated with diuretics, and the response served closely, or INDERAL should be discontinued (gradually, if possible).

N PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of ina following abrupt withdrawal of propranolol therapy and discontinuance of NDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage hould be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If NDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advis- able to reinstitute INDERAL therapy and take other measures appropriate for the man- agement of unstable angina pectoris. Since coronary artery disease may be unrecognized, t may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) – PATIENTS ITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA OCKERS. INDERAL should be administered with caution since it may block bronchodilation oduced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists, and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. General Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular System. Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory bronchospasm.

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained release capsule for administration once daily If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL tablets. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION – *Dosage must be individualized* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS – *Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE – *Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS – 80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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New York, N.Y. 10017

Trace Element Nutrition

JOHN D. BOGDEN, Ph.D., Newark*

Practicing physicians should be aware of symptoms and modes of treatment of diseases associated with abnormalities of trace element metabolism. Patients of the alert clinician can benefit from this awareness, since recent studies have demonstrated that diseases and conditions due to or affected by alterations of trace element status are more widespread than previously suspected.

New knowledge about the clinical importance of trace element nutrition and metabolism has resulted from improvements in the capability of laboratories to analyze blood and other samples for trace elements and from recognition in man of deficiencies previously observed in domestic and experimental animals. The purpose of this article is to outline diseases associated with abnormalities of trace element metabolism, especially those more likely to be observed by the practicing physician.

The term "trace element" often is used imprecisely; here it is meant to include those substances present in the diet in microgram or milligram quantities. Thus, zinc, with a typical daily intake of 10 to 20 milligrams, is considered a trace element, but calcium, with a usual daily intake of 1,000 milligrams, is not. The above distinction means that the essential elements hydrogen, carbon, nitrogen, oxygen, sulfur, phosphorous, sodium, potassium, magnesium, calcium, and chlorine are not trace elements. The first five, of course, are major components of proteins, carbohydrates, nucleic acids, and lipids, while the latter five are major electrolytes.

There are nine trace elements that currently are known to be essential for man: iodine, iron, copper, zinc, manganese, cobalt, molybdenum, selenium, and chromium.[1-7] Requirements and diseases associated with iodine and iron have been long established and well described, and these elements will not be discussed in this review, which will focus on the latter seven trace elements.

In addition, there is another group of trace elements th may be regarded as possibly essential. This group consis of tin, fluorine, vanadium, silicon, nickel, aluminum, stro tium, barium, pentavalent arsenic, lead, and cadmium.[2] While there are not recognized deficiencies in man or u equivocally established metabolic roles for these element there are data suggesting that each of these elements is esse tial for at least one laboratory or domestic animal. It is like that at least some of these eventually will be shown to b essential for man. For other trace elements such as mercu and trivalent arsenic, there are no studies demonstratin essentiality in animals. However, this should not be inte preted to mean that they never will be shown to be essentia but only that no evidence exists at the present time. Medic history has shown that trace elements such as selenium i itially considered quite toxic may be essential to man animals in very small quantities.

SOME BASICS

It is helpful to understand the following ideas and pri ciples prior to consideration of specific diseases associate with trace elements.

1. Interactions among trace elements may affect the clinical manifestations. For example, anemia due to copp deficiency may develop in patients receiving high doses

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zinc because zinc inhibits gastrointestinal absorption and tissue utilization of copper.[2,3,5]

2. Dose-response effects must be considered. Severe zinc deficiency may develop from inadequate intake, but an excessive intake may produce anemia and eventually death.[2,5] All trace elements are toxic if the dose is high enough.

3. Trace metals exert profound effects on metabolism because they interact with and affect the function of enzymes, or are a part of the enzyme molecule itself. Trace elements with molecular weights of less than 100 can influence the activity of enzyme molecules with very high molecular weights; thus microgram or nanogram quantities of trace elements may be responsible for the metabolism of gram quantities of other nutrients. For example, through its presence in "glucose tolerance factor" nanogram quantities of chromium influence the regulation of energy metabolism (1,500 to 4,000 kcal/day).[6]

4. Chelation may strongly influence trace element metabolism. Many drugs are chelating agents, e.g. ethambutol, EDTA, penicillamine, isoniazid. When using such drugs, the physician should consider their effects on the metabolism of essential metals. A chelating agent is a molecule that can bond to transition metals (e.g. iron, copper, zinc, chromium) with two or more bonds, thereby forming a ring structure. Rings containing five or six atoms are thermodynamically very stable.[4]

5. The physician must distinguish between cause and effect. Alterations in copper metabolism do not lead to Hodgkin's disease, but once the disease is established it affects copper metabolism, producing large increases in plasma copper.[6]

"There are nine essential trace elements: iodine, iron, copper, zinc, manganese, cobalt, molybdenum, selenium, and chromium."

6. In vivo trace metals generally are bound to the sulfur, nitrogen, and oxygen atoms of proteins. Thus, they usually are present in relatively high amounts in high protein foods, though there are a number of exceptions to this generalization. For example, tea has a high manganese content and pepper a high vanadium content.[1,5]

7. Adequate intake of trace elements does not necessarily imply adequate bio-availability. For example, the severe zinc deficiency identified in the Middle East during the 1960s developed in part because of a high dietary phytate content. Phytate may lead to zinc deficiency by decreasing gastrointestinal absorption of zinc.[2,5]

8. The treatment of a disease, not the disease itself, may produce alterations in trace element metabolism. For example, ethambutol, a chelating drug used to treat pulmonary tuberculosis, produces a decrease in visual acuity in some patients that has been associated with its interaction with ocular zinc.[4] Patients receiving total parenteral nutrition (TPN) for any of a variety of reasons may develop symptomatic deficiencies of copper, zinc, selenium, chromium, and molybdenum.[8-14]

The above ideas should be kept in mind when evaluating patients or assessing the clinical literature on trace elements.

ZINC

Zinc deficiency first was suspected to occur in man in 1961, in Iran, and it was established subsequent to comprehensive studies in Egypt in 1963.[2,5] Males appear to be more readily affected than females. Symptoms are dwarfism, testicular atrophy, retardation of sexual maturation, and decreased serum alkaline phosphatase; all responded favorably to zinc supplementation. The reasons for development of severe zinc deficiency in males in Iran and Egypt are still uncertain, but probably relate to low protein intake, high dietary phytate, and geophagia.

More recently, a congenital life-threatening disease—*acrodermatitis enteropathica*—has been shown to be a severe zinc deficiency.[15] *Acrodermatitis enteropathica* is a rare, autosomal recessive disorder, characterized by skin lesions, diarrhea, alopecia, anorexia, severe failure to thrive, growth retardation, delayed sexual maturation, and increased susceptibility to infection. Victims have very low plasma zinc concentrations. If untreated, the disease generally is fatal, usually as the result of infection that does not respond well to the usual therapies. The primary defect is a failure to absorb zinc adequately from the gastrointestinal tract. However, absorption is not completely inhibited and administration of oral zinc supplements results in rapid recovery. Thus, this is a zinc deficiency that develops even in the presence of adequate dietary zinc because of inadequate absorption and availability to tissue.

The skin lesions and alopecia found in *acrodermatitis enteropathica* also have been reported in numerous patients receiving total parenteral nutrition (TPN) solutions containing inadequate quantities of zinc, since TPN solutions vary widely in their content of zinc and other trace elements.[9-14] For most patients, at least four weeks of TPN is needed before zinc deficiency develops.[11] Treatment consists of adding zinc to the TPN solutions.

Disorders of malabsorption may produce conditioned zinc deficiencies, and there are reports of victims of Crohn's disease developing symptomatic zinc deficiency.[2] Similar reports of zinc deficiency in patients after intestinal bypass surgery also have been published.

The combination of low birth weight, parenteral supply of nutrients, and diarrhea is especially likely to lead to zinc deficiency in the postnatal period. In such patients, the parenteral solutions should be supplemented with zinc. It has been suggested that all infants with protracted diarrhea should be checked for zinc deficiency,[15] and this is a reasonable suggestion, especially since zinc deficiency may make such patients immunodeficient and thereby likely victims of opportunistic infections.

Uremic patients have a tendency to be zinc deficient. The anorexia, decreased taste acuity, and impotence seen in such patients may respond to oral zinc in some cases. However, caution must be exercised before recommending zinc supplements for hemodialysis patients, since they already may be receiving excessive quantities of zinc as a result of zinc contamination of some types of disposable dialysis coils.[16] In fact, the literature contains a number of reports of acute zinc and copper toxicity with occasional fatalities in hemodialysis patients dialyzed with contaminated solutions.[16]

Numerous other conditions such as severe burns, tuberculosis, other infectious diseases, uremia, and pregnancy are associated with moderate to large decreases in the plasma zinc concentration.[2,4] This does not mean that patients with such conditions are necessarily zinc-deficient, since these

diseases may induce a redistribution of zinc among body tissues, specifically a flux of zinc from plasma to the liver.

COPPER

Next to zinc, copper has received more attention from the medical community in recent years than other trace elements. Wilson's disease (hepatolenticular degeneration), a rare autosomal recessive disorder, has been recognized for a number of years.[1,2,5] Although plasma copper concentrations and plasma ceruloplasmin (the major copper-binding protein in blood) concentrations are low, tissue copper concentrations are high and the latter exert toxic effects on the liver, brain, and kidneys. Fortunately, this serious disease can be managed by life-long administration of the chelating agent D-penicillamine, which prevents excessive tissue copper deposition by promoting its excretion. D-penicillamine also has been used in the treatment of lead poisoning and, in fact, will chelate not only lead and copper, but other trace metals such as zinc. This nonspecificity of drugs that are chelating agents must be considered when such drugs are administered, especially over extended periods of time. In fact, there is a report of a Wilson's disease patient receiving penicillamine who developed symptomatic zinc deficiency, including severe skin lesions and alopecia. Because of the nonspecificity of D-penicillamine, research to find other drugs for the treatment of Wilson's disease continues, and a recent report suggests that high doses of zinc may be successful in the management of Wilson's disease.[17]

In contrast to the copper toxicity of Wilson's disease, Menkes' (kinky hair) syndrome is a recessive X-linked and uniformly fatal disorder of copper metabolism characterized by inadequate copper utilization by tissues.[1,2,5] It appears to be a defect in the transport of copper across cellular membranes. Symptoms include progressive cerebral degeneration with frequent seizures, abnormal elasticity of the arteries, tortuosity of abdominal and intercostal vessels, temperature instability, and increased susceptibility to infection, with death at an early age. Neither parenteral nor oral administration of copper is effective in treatment of this disease. Victims have low plasma copper and ceruloplasmin concentrations as in Wilson's disease, but do not have excessive tissue copper concentrations. The effects of Menkes' disease on blood vessels suggest that copper plays a critical role in maintaining the integrity of the cardiovascular system.

A syndrome of neonatal copper deficiency has been well described in the medical literature; prominent features in order of appearance are neutropenia, leukopenia, bone demineralization, and failure of erythropoiesis.[2,5] Particularly at risk are low birth weight infants and malnourished infants with chronic diarrhea. Unfortunately, plasma copper and ceruloplasmin are highly dependent on age in infants and their determination is of limited value in the diagnosis of copper deficiency in these patients.

Copper deficiency also has been found in children and adults receiving TPN with fluids with an inadequate concentration of copper. Symptoms are low plasma copper concentrations, neutropenia, leukopenia, and a hypochromic microcytic anemia unresponsive to iron administration.[10] Malabsorption disorders such as Crohn's disease also may lead to copper deficiency as a result of inadequate absorption.

SELENIUM

There have been several reports in the literature concerning patients who developed selenium deficiency afte prolonged parenteral nutrition. In one case intermittent le muscle pain and tenderness and increases in serum activitie of aspartate aminotransferase and alanine aminotransferas were observed after 1½ years of TPN. In addition, the patien developed white fingernail beds and had a very low serur selenium concentration. Serum enzyme activities markedl improved and the fingernail bed abnormalities responded t intravenous selenium supplementation.[12]

In another case, a 37-year-old woman developed seleniur deficiency after one month of TPN.[9] This relatively rapi development most likely was due to the fact that she live in an area of New Zealand in which endemic white muscl disease in sheep is controlled by selenium supplementation her diet probably was low in selenium. She developed sever muscle pain and tenderness in the thighs with a resultin inability to walk; this responded to treatment with seleniur within one week. Her plasma selenium concentration wa less than 1/10 the normal mean.

Of greater interest is the possible causal relationship be tween selenium deficiency and some forms of cardio myopathy. Keshan disease is a pediatric cardiomyopath endemic across a broad area of China.[18] Domestic animal living in these regions are known to develop selenium defi ciency. It is fatal in 90 percent of untreated cases and als in a large percentage of treated cases. Although selenium i of no value once the disease is present, studies of seleniun supplementation of several thousand Chinese children dem onstrate that regular selenium supplements can produc substantial reductions in the incidence of Keshan disease

The areas in which Keshan disease is endemic have lo soil selenium concentrations and the food supply, whic almost exclusively is grown locally, is low in selenium. Thi type of situation is unlikely to occur in countries such as th United States, where soil selenium concentrations, particu larly in the Plains states, are relatively high,[1] and where foo is distributed widely. Nevertheless, recent case reports hav shown low blood and heart selenium concentrations in som American residents with cardiomyopathy.[8,19] The activity o glutathione peroxidase, a selenium containing enzyme, als was reduced in these patients. One patient was an adult mal who developed a selenium deficiency and fatal cardio myopathy after six years of home parenteral nutrition.[8]

CHROMIUM

The primary metabolic role of chromium appears to b related to the presence of chromium in the "glucose tolerance factor," a compound that acts as a cofactor for insulin facilitating binding with its receptors and amplifying knowr effects of insulin. Chromium deficiency may cause insulir resistance, hyperinsulinemia, and impaired glucose tolerance which can be reversed by chromium supplementation.[20]

Several cases in which chromium deficiency developed ir patients receiving long-term TPN have been reported.[13,2] Symptoms of chromium deficiency were glucose intolerance and a peripheral neuropathy; both are reversed by chromium supplementation but not helped by insulin administration.

There also is evidence that pregnant women, especially those who have had several pregnancies, may require additional chromium and/or have inadequate chromium stores. Unfortunately, reliable laboratory tests for chromium are not readily available except at laboratories with considerable experience in performing plasma and hair chromium determinations.

MOLYBDENUM

It is likely that the essentiality of molybdenum is related to its being a component of the enzymes anthine oxidase and sulfite oxidase. There is one report of a patient developing molybdenum deficiency.[14] The patient was a 24-year-old male with Crohn's disease diagnosed 12 years earlier and who had been maintained on total parenteral nutrition (TPN) as the only method of support for 18 months. Symptoms of molybdenum deficiency in this patient included intolerance to amino acids, particularly L-methionine, while on TPN. The patient displayed tachycardia, tachypnea, central scotomas, night blindness, and irritability. The symptoms disappeared after discontinuation of administration of amino acids. Biochemical tests for plasma uric acid and methionine and urinary uric acid, sulfate, thiosulfate, hypoxanthine, and xanthine suggested an underlying defect in sulfur amino acid metabolism with regard to the transformation of sulfite to sulfate and in uric acid metabolism. Sulfite oxidase catalyzes the transformation of sulfite to sulfate and xanthine oxidase catalyzes the transformation of xanthine and hypoxanthine to uric acid. Both of these are molybdenum enzymes. Treatment of the patient with ammonium molybdate improved his symptoms and corrected both uric acid production and the defect in handling sulfur.

COBALT

Cobalt is essential only because it is a component of cyanocobalamin (vitamin B_{12}). As a result, the turnover of only 10^{-10} (0.1 nanograms) of cobalt is responsible for the daily turnover of gram quantities of protein.[6] This ability of small quantities of trace elements to affect the metabolism of much larger quantities of other substances is termed amplification.

MANGANESE

Manganese deficiency in man has not been reported, but manganese is considered essential because of the known existence of several manganese metalloproteins; for example, superoxide dismutase, pyruvate carboxylase, and concanavolin A, and because numerous additional enzymes are activated by manganese.[1,5]

However, manganese toxicity is a well-known entity that occurs among manganese workers, particularly miners.[7] The primary effects are upon the central nervous system. Among miners in Chile, manganese toxicity is known as "mangamic madness" and is characterized by irritability, difficulty in walking, speech disturbances, abnormal gait, and muscle aches. Other features may include headache, tremors, and compulsive behavior.

LABORATORY EVALUATION

Reliable laboratory analyses of blood for trace elements generally are available only at research centers. Analyses for copper, zinc, and selenium are more readily available than analyses for chromium, manganese, cobalt, and molybdenum. Of particular importance is knowledge of correct procedures for sample collection and processing. Samples collected in vacutainers generally are not suitable, particularly for zinc, since vacutainers tend to produce gross contamination of blood samples with this metal.[4] The zinc comes from the rubber stopper and/or the silicone lubricant around the stopper. There currently is available a blue-stoppered vacutainer that is intended for collection of blood for trace metal analyses, but there are published reports that even this vacutainer produces specimen contamination with zinc. At the UMDNJ–New Jersey Medical School, we use only acid-washed polypropylene tubes for the collection, centrifugation, and storage of blood and plasma samples.

We test each batch of anticoagulant (EDTA) prior to use and select only batches that are free of excessive trace element contamination. In any case, it is best to consult with the laboratory prior to collecton of any samples for trace element analyses. The analyses generally are performed by atomic absorption spectrophotometry, though fluorometric methods usually are used for selenium determinations.

Considerable expertise is required in the interpretation of blood and plasma trace element concentrations. For example, a variety of conditions such as infectious disease produce elevations in the plasma copper concentration and this might mask an otherwise low concentration.[1,4,5]

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Annual Report

DAVID I. CANAVAN, M.D., Lawrenceville*

It seems appropriate to report to the Board of Trustees of the Medical Society of New Jersey on the activities and accomplishments during the first year of my tenure as Medical Director of the Impaired Physicians Program. The following is our annual report, September 1982 to September 1983.

1. **Program Issues**

a. Organizational structure established—Impaired Physicians Program; Committee on Impaired Physicians, Executive Subcommittee and Panel of Intervenors/Monitors; and Board of Directors.

b. Mission statement finalized.

c. Guidelines for hospitals endorsed.

d. Protocols for referrals established.

e. Close liaison with State Board of Medical Examiners established.

2. **Educational Activities**

a. *The Journal,* MSNJ, ongoing series of articles; eight articles to date.

b. Articles in *The Shingle* (MSNJ Auxiliary), New Jersey Family Physician (NJAFP), and newsletter of the Princeton Insurance Company.

c. Widespread publicity throughout the state in newspapers.

d. Presentations at:

(1) State Medical Society Functions	4
(2) County Medical Societies	11
(3) Hospital Medical Staff Meetings	19
(4) Rotary Clubs	2
(5) Specialty Societies	2
(6) Mini Residency CDS (UMDNJ)	2
(7) Medical School Lectures	2
(8) AA Meetings	2

(9) Philadelphia County Medical Society Seminar "Impaired Physician"

(10) Risk Management Seminar, PIC

(11) Morris County Bar Association Seminar—"Drunk Driving"

3. **Urine Monitoring Program**

Through the cooperation of the Division of Laboratories of the New Jersey Department of Health, we have established a program for ongoing urine monitoring for our substance abusing clients. Urines are collected under supervision, forwarded to the Department of Health Laboratory using a code number, and reported to our office. The cost to the physician-client is $7.00 per specimen and allows us to test for four different classes of drug in each specimen. The randomicity of testing is controlled through our office at MSNJ headquarters. Urine monitoring provides three benefits: (a) it is a constant reminder that the physician is being observed; (b) it is an effective "early-warning" system; and (c) it is invaluable evidence of the drug-free state for future use in defending the physician's recovery before administrative or disciplinary boards.

4. **Statistical Report**

(a) Case load	103 physicians
New cases	79
Old cases (active before 9/7/82)	24
M.D.	85
D.O.	12
Medical student	2
D.P.M.	1
D.V.M.	1
Ph.D. (UMDNJ)	1
D.C.	1
Male	98
Female	5
(b) Impairment	
Alcohol alone	36
Alcohol/drugs	16
Drugs alone	25
Psychiatric	18
Senility	5
Other disability	3
Awaiting confirmation/confrontation	11

*Dr. Canavan is Medical Director, Impaired Physicians Program. Correspondence may be addressed to Dr. Canavan, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.

(c) Hospitalized

Detox/rehab	36
Psychiatric	10

(d) Present Practice Status

In active practice	72
Seeking employment	9
Disabled/retired	15
License suspended	3
License revoked	2
Unable to locate	1
Deceased	1

Referred to New Jersey State Board of

Medical Examiners	5
License revoked (psychiatric)	2
License retired (senility)	3

Advocacy on behalf of clients:

1. NJSBME	
a. Appearances	11
b. Letters of support	7
2. Hospital staff	
Committee appearances	5

(e) Urine Monitoring

3 in Program are being screened elsewhere: 1 at our direction, 1 out of state, and 1 at direction of his counselor.

2 being screened by Dr. Barnet.

20 being screened at state labs at our direction.

5. **Treatment Loan Fund**

Efforts have been made during the past year to accumulate funds into a special account managed by the Director of Finance and Adminstrative Services of MSNJ to assist our clients in meeting expenses of treatment or living expenses during their absence from practice. Our initial thrust was directed to a limited number of pharmaceutical houses. The results of that effort to date have been:

Drug Company	Grant	Future Pledge
Warner Lambert	5,000	10,000
E. R. Squibb & Son	250	—
American Home Products	1,000	—
Merck & Company	5,000	—
Sandoz, Inc.	3,000	7,000
Total	$14,250	$17,000

To date, three loans have been made from this fund totaling $3,121.00. Loans are made for a period of two years. Interest alone at 3 percent is due on the first anniversary and 1/12 of the principal plus interest accumulated is due in 12 monthly installments during the second year. The Board of Trustees has approved an ad in *The Journal* to solicit the membership for voluntary contributions to this fund.

6. **Malpractice Experience Review**

As part of our review of our first year's experience, we initiated a study of the experience of the malpractice carriers in claims against "impaired" physicians as compared to those who were not known to be impaired. Preliminary data from the MIIENJ suggest that in the "impaired group" there was a 30 percent higher incidence of claims. This would suggest that the initial impression of the carrier was valid and should encourage their continued support.

7. **Problems**

In our first year of operation certain problems have surfaced in the operation of the program. These include:

(a) *Denial*—On the part of some members of the profession of the incidence of "impairment" in our colleagues.

(b) *Documentation of the Impairment*—A significant amount of time and effort is required to gain solid irrefutable evidence of the existence of the impairment so that the client can be confronted.

(c) *Followup*—The ever-increasing number of clients produces a real burden in keeping close track of the individual progress on each one. Our panel of intervenors and monitors is helpful here, but again, the issue of their limited availablity does present difficulties.

(d) *Auxiliary Involvement*—I have been disappointed in our progress in bringing the Auxiliary into our Program. This is as much our fault as anyone's. Time demands have made it hard to devote adequate effort to this important area of our concern.

(e) *Psychiatric Panel*—While we have had the approval in principle of the formation of a panel of members of the New Jersey Psychiatric Association to assist in evaluation of physicians with psychiatric impairments, so far we have not been able to implement this panel.

(f) *Employment Issues*—One of the major problems that confronts the recovering physicians is the issue of returning to employment in some capacity in the ranks of the profession. Physical disabilities, the need to change professional pursuits, and restrictions imposed by the State Board of Medical Examiners are all important factors on the physician's side. On the employer's side, there is a great deal of resistance to "sticking their neck out" for someone who presents an increased risk of malpractice liability, or negative "community image." A lot of effort is needed here to educate potential employers about the excellent progress for long-term recovery that many of these clients have.

(g) *State Board of Medical Examiners*—After a full year of working closely with the Board, I am forced to conclude that there seems to be a lack of real understanding of the diseases of impairment, especially on the part of some of the newer members. The tendency to treat these physicians as defendants in a disciplinary hearing can be demeaning.

8. **Goals**

It would be inappropriate to present the review of the last year without offering some realistic goals for the year ahead:

1. Push vigorously ahead in our educational program to spread the word about impairment and recovery to all the physicians in our state.

2. Expand the panel of intervenors and monitors to spread the followup burden over a wider base.

3. Foster closer ties and participation with the Auxiliaries.

4. Attempt to get the Psychiatric Panel implemented.

5. Vigorously pursue employment opportunities for our "recovering" colleagues.

6. Attempt to convene a one-day seminar on "impairment" for members of the State Board of Medical Examiners and other agencies concerned.

7. Expand the program staff to include a full-time certified alcoholism counselor as a salaried employee to assist in: education, documentation, confrontation, followup, auxiliary involvement, and employment.

In summary, the past year has far exceeded even my own optimistic expectations. I hope that the momentum we are gaining will continue to assist us in finding our troubled colleagues and in leading them back to the path of recovery and self-respect.

Time To Act On Organ Transplants

JIM COURTER, Washington, D.C.*

In recent months, we have become painfully aware of the plight of a number of children requiring organ transplants to survive. The public easily can identify Jamie Fiske as the young girl whose father, a hospital administrator, used the media to find the liver she needed to stay alive. Several other children have become household names since their families went public with their appeals for organ donations. The exposure paid off and these children received suitable organs.

Unfortunately, the names of most children in need of life-saving organs do not ring a bell. The specific appeals which have received media attention have led many to misunderstand the magnitude of the problem of organ transplantation. Literally, tens of thousands of children and adults will need kidney, cornea, pancreas, heart, and liver transplants this year. For example, it is estimated that between 40 and 50 children a day require liver transplants alone. Obviously, the call for organ donors is far from an isolated situation.

To many people's great surprise, organ transplants can be and are being conducted with greater frequency and success (while higher for some organs than others, on the whole, the survival rate exceeds 50 percent). New Jersey has had a unique role in the viability of transplantation: the increasing success rate largely is attributed to the discovery of cyclosporin A, developed by Sandoz, Inc. of East Hanover. Cyclosporin A combats the body's rejection of the foreign organ. Thanks to the use of this drug, combined with a more advanced understanding of the body's immune system and better surgical techniques, a number of hospitals now consider transplantation to be a service rather than an experimental surgery.

The potential for saving lives through transplants seems endless. Yet, a number of factors have made it difficult or impossible for patients to take advantage of this procedure, even when there is no alternative. Regardless of the medical capability to perform transplants, the operation cannot be conducted without an organ donation. Regrettably, most people are unaware of the need for organs. As a result, only 2,500 of a potential 20,000 kidneys actually were donated in 1982; only 100 out of a needed 4,600 liver transplants will be performed in 1983; and only 100 out of 12,000 heart transplant candidates will undergo the operation in 1983.

Heightening the public's awareness of the dimensions of this problem is part of the answer. Emergency broadcast appeals for organs will not always be effective, and they cannot begin to serve the large number of patients in need of transplants. The designation of September as "Organ Donor Month" in New Jersey certainly was a useful way of sparking statewide interest in this issue. The state legislature also recognized the need for greater sensitivity to the problem of organ procurement by enacting a law requiring that organ donor cards be sent to Garden State residents with the driver's license. More must be done, however, to educate the public, the clergy, and public safety officers on the issues of transplantation and its procurement. In addition, greater coordination is needed between the over 100 national agencies which try to fulfill the demand for organs.

The patient who is lucky enough to find a suitable donor organ will face the problem of how to pay for implantation. The price tag for this procedure truly is staggering, with the most expensive surgery, liver transplant, costing an average of $100,000 per patient. Organ transplants are becoming more widely accepted in the medical and science communities, and The National Institutes of Health has determined that several types of organ transplants are the appropriate therapy for certain groups of patients. But private insurers, Medicare, and state Medicaid programs view many of these transplant operations as experimental rather than therapeutic and are reluctant to include them under standard coverage. It is believed widely that Medicare's reclassification of organ transplants as therapeutic will encourage other insurers to follow suit. Two young children in New Jersey's 12th District were fortunate to find the liver donor matches they needed for survival. However, much of the cost of their operations was not picked up by medical insurance, and, as a result, their parents had to engage in fundraising activities to cover the remaining amount. Until a systematic policy of medical coverage exists, families will continue to be forced to utilize desperate measures to pay for transplants.

A medical procedure which can save countless lives should not be overlooked or under-utilized because of public ignorance. Clearly, the government can play an important role here in the form of expanded research assistance. By removing certain medically sound transplant operations from their "experimental status," the government will send a positive signal which will foster reimbursement of transplant claims by private insurers and Medicaid. Such efforts will go a long way toward developing a climate whereby last-minute emergency appeals no longer are necessary.

*Representative Jim Courter, Republican from New Jersey, is a member of the House Select Committee dealing with health and long-term care as well as the Armed Forces Committee and the Post Office and Civil Service Committee.

President's Column

Alexander D. Kovacs, M.D.
President

This thought must have occurred to many of you: "Are hospitals our friends or our enemies"?

Hospitals evolved over the years from places to care for the very ill or dying to ultramodern facilities providing comprehensive care. With the advent of insurance coverage for health care and increasing technology, hospital use increased. Hospitals became known as the "doctors' workshops."

Around 1946, the Hill-Burton Act came into being. Planning was required before building but this did not prevent inefficient facilities from being constructed.

In the 1960s, Medicare and Medicaid were enacted to equalize medical care for all, as health care became a "right." This was on a cost-of-care basis but there was no real incentive to decrease costs. Since Medicare paid for 85 percent of the charges and Medicaid for 60 percent, costs were shifted to private payers.

The government authorized further planning and control (i.e. CON, HSA) which were more of the same "cost controls" whose philosophy was "if it does not work, do more of the same but harder." Of course these regulations added more to health care costs. Since physicians admit, treat, and discharge patients, our every act increased costs.

With increased specialization in the 1960s, there were less family physicians. Hospital clinics and emergency rooms took their places. The working population started to move to the suburbs, the indigent and the elderly were left behind, and urban hospital costs rose as income decreased.

A desperate race was on to get certificates of need and financing for



Alexander D. Kovacs, M.D.

sophisticated technology which would enable inner city hospitals to survive, to close down money losing departments, and open dialysis units, coronary care units, and other expensive regional care areas. This regionalization actively was encouraged by HSA.

Despite these measures, a tried and true marketing principle was at work. The businessmen who put up shopping malls figured it out sooner. You have to go where the people are. So what are hospitals doing now? Building and marketing ambulatory care centers and hiring doctors to work in them. Since there is and will be a surplus of physicians, hospitals can hire them at competitive salaries. Hospital-based physicians provide ancillary and support services, full-time emergency room services, ambulatory care, health education, executive business screening, and industrial medicine. Hospitals are increasing their public relations and marketing services via television, radio, and newspapers. They are providing outreach services such as home health care, hospice care, outpatient surgery, alcohol and substance abuse, patient transport, as well as mobile units for emergencies.

Proprietary hospitals treat only paying patients, avoid Medicaid patients, and make money. Consequently, almost 30 percent of all beds in the United States are owned by proprietary or investor-owned hospitals. This makes a dynamic force for a change in the health care industry.

Of course, nonprofit hospitals also have taken major steps in order to survive. One is "unbundling," where they restructure themselves corporately in order to protect their revenues from the IRS and from being used to offset Medicare reimbursements (any raised money, as fund drives, is subtracted from Medicare reimbursement). Restaurants, laboratories, and any other profit-making departments are spun off; any profits are sent to a foundation so the hospital does not show it is making money. A second step is the development of systems to take advantage of economics of scale, by two or three neighboring hospitals sharing a laundry facility, new equipment, architect and engineering services, administrative services, and bulk buying of supplies.

Unfortunately, this is leading to an adversary relationship between us and the hospitals. It is a jolt to discover the hospital which was your handmaiden now actively is competing with you for patients. Despite the change in our relationship, neither of us can deny that we absolutely need each other. The money available for health care is becoming fixed. It neither is dignified nor sensible to quarrel over who gets what. Common sense tells us the time has come to negotiate for the benefit of our patients, the hospitals, ourselves, and the public purse.

What can we do? What should we do? We have to recognize what is coming

and begin to work with hospitals. There has to be a medical staff-hospital partnership for market development to cope with competition, preserve symbiotic relationships, develop capital, explore the real potential of IPAs and PPOs, and initiate greater involvement in government relations and the political process.

The business community is not going to pay increasing sums of money without an accounting and real input as to the bang they get for their dollars.

We must recognize that political realities have changed the practice of medicine as drastically as technology. We have embraced the one and ignored the other. For only a little longer we have an opportunity to become an active participant in the newly evolving practice of medicine or to accept that we will become a fully regulated and controlled public utility.

Do not for a moment think our position is a weak one. We have the knowledge and we have the numbers. At this point in time, we can still effect beneficial change if we unite for that purpose. One thing is unmistakably clear. The status quo is not an option.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

Dedication of the Center for Human Molecular Genetics on the Piscataway campus in mid-October was one of those exciting events which bring to the fore the worth of the efforts being made throughout UMDNJ to advance the health sciences in the Garden State.

Research carried out at the Center may bring more effective treatment for such diseases as arthritis, diabetes, heart disease, and stroke. Earlier identification of people who are more susceptible to those diseases is another potential benefit.

Governor Thomas H. Kean, who led a gathering of dignitaries and scientists attending the ceremony, expressed the broad public interest in this new research center in his remarks about the importance of preventing disease and maintaining good health. His assertion, "nothing is as important as human health," recognized the importance of the contribution those in medicine make in research and clinical application.

Under the direction of Darwin J. Prockop, M.D., Ph.D., the Center will be used by scientists from both the clinical and basic science departments of UMDNJ-Rutgers Medical School. The research activities are funded primarily by grants from the National Institutes of Health, with additional support from Johnson & Johnson and the Becton-Dickinson Company.

The first phase of research is devoted to studying brittle bone disease or osteogenesis imperfecta, a relatively rare disease in which bones are so fragile that infants can die at birth. The new techniques of gene cloning now make it possible to analyze in great detail the molecular bases of such genetic diseases. Over the past several years, scientists at the UMDNJ-Rutgers Medical School and other institutions have demonstrated that most variants of brittle bone disease are produced by mutations in the gene for collagen, the fibrous protein that holds together the cells and tissues of the body.

The research group at the UMDNJ-Rutgers Medical School prepared the first cloned genes for human collage several years ago. A June 1983 issue o the leading British journal, *Nature,* re ported that one lethal form of brittl bone disease is produced by a mutatio which deletes part of one of the gene for collagen. An article appearing in th *Journal of Clinical Investigation* pres ented results that should make it pos sible in the near future to carry ou DNA tests for the prenatal diagnosis o brittle bone disease. The procedure would be similar to those currently i use for the prenatal diagnosis of sickl cell anemia.

From these and other laboratory re sults, it is apparent that effective test soon will be available for determinin whether brittle bone disease is present i a fetus at about 16 weeks of pregnancy an early decision can be made as t whether to allow the pregnancy to cor tinue.

Scientists at the Center already hav begun the next phase of their researc focusing on more common diseases.

The hypothesis for this second phas is simple: If mutations which make larg changes in collagen genes produce sever disorders such as brittle bone diseas early in life, perhaps smaller changes i the same genes produce diseases whic are not seen until an individual become middle-aged or older.

This hypothesis is attractive to scien tists because collagen is an extremel stable and long-lasting material. Most o the collagen acquired in bones, skin, an blood vessels during infancy and durin the growth spurt of adolescence remain with an individual for the rest of his/he life. Therefore, it seems likely that som individuals inherit genes for collage that produce collagen only slightly dif ferent from normal. These people may enjoy good health throughout early life but because of the natural wear and tea of collagen-rich tissues over 40 or 5 years, they may develop the bone o blood vessel diseases that are a majo cause of the medical problems in adults A minor defect in a collagen gene may create the "predisposition" to a disease such as osteoporosis, the fragility o bones seen in many older women, or th blood vessel diseases that lead to hear attacks and strokes.

The concept of such a "predisposi tion" to a slowly-manifesting disease is familiar to physicians who long have been aware that certain individuals and families have unusual tendencies to ac quire specific diseases of middle age.

Testing the hypothesis that minor de fects in collagen predispose an individ

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al to diseases in adult life presents some ajor technical problems. The collagen enes are unusually large and, therefore, nall changes in the genes are difficult detect even with the latest techniques. owever, the scientists at the Center for uman Molecular Genetics find that eir work on the easier target of brittle one disease repeatedly is providing em with the information needed to ake their experimental tools more phisticated.

If the hypothesis is correct, it may itiate a new approach to the treatment a broad spectrum of diseases. Physicians will be able to predict years in dvance who is destined to develop a iven disease later in life. They will have nformation with which to prescribe ecific preventive measures.

If the hypothesis is correct, it probbly will have a major impact on varying eatment for different patients with the ame diseases. Therapies now are effecve for a few patients with osteoporosis f arthritis, but useless for others.

One likely explanation for the varitions in response is that although the nd stages of the disease are similar, the nolecular bases are different. Analysis f the genes from patients is likely to how how the patients differ at the nolecular level and provide a rational asis for prescribing specific treatments or each patient.

The first cloning of human collagen enes—the research which allowed delopment of the Center—was carried out by a research team consisting of Drs. Francesco Ramirez, Mon-Li Chu, and Jeanne Myers; together with Dr. Prockop, they continue to be involved in the experiments in which collagen genes from patients with brittle bone disease are examined.

The current work on brittle bone disease also includes Dr. Petros Tsipouras, a clinical geneticist from the Department of Pediatrics, UMDNJ-Rutgers Medical School, and additional investigators. Six senior scientists now are working full time in the Center, and collaborative projects involve seven members of the clinical faculty from the departments of medicine, surgery, and obstetrics and gynecology.

MSNJ Auxiliary

Gale Wayman
President

We now are in the midst of the "holiday season," a time for sharing, and your Auxiliary has been sharing its time, effort, and money for many worthy causes. Every county is unique and, therefore, is meeting the needs of their county in a variety of ways.

In Gloucester County, the Auxiliary put together a wonderful cookbook, "Blending the Seasons," to raise money for their scholarship fund. The Auxiliary members not only contributed the recipes but then tested each and every one of them, sacrificing their waistlines for the good of medical education.

In Camden County, a "linen shower" was held for the Ronald MacDonald House, a newly opened facility for the families of seriously ill children to use while their children are in the hospital or receiving "outpatient" treatment for diseases such as leukemia and other severe blood disorders. A tour was given to the Auxiliary of the refurbished three-story Victorian building located across the street from Cooper Hospital, Camden. The facility also is open to families from other nearby hospitals. This is the first Ronald MacDonald House in New Jersey; there may be one coming to northern New Jersey in the future.

In other areas of the state, counties are working to set up and aid MADD chapters (Mothers Against Drunk Drivers); this follows the national program of awareness and prevention of drunk driving. MADD now is sponsoring a large fundraising campaign to help set up new chapters and work on legislation. Our working with such groups is part of a national coalition program encouraging the Auxiliary to work with other health-related groups.

During the course of my term, I will continue to keep you informed of your Auxiliary's activities. I wish you all a very "Happy Holiday."

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AMNJ Report

Paul J. Hirsch, M.D.
President

Our "First Wednesday at the Academy" program had an excellent start on October 5, 1983. The guest speaker was Mr. William Toby, regional administrator for Region II of the Health Care Financing Administration. Mr. Toby spoke "off the record" and forthrightly about DRGs and prospective payment schedules in New Jersey, and in the nation. He stated that HCFA now has an 80 billion dollar annual budget—the third largest in the federal government. He reported that there will be a conference on DRGs in New Jersey in the near future. This program, sponsored by Governor Kean, is entitled, "The Lessons of New Jersey and the Implications for the Nation, under DRG." Representatives from 50 states will attend. In response to a question about prospective reimbursement schedules for physicians' services, Mr. Toby

stated his opinion that this was at least ten years off. He feels that the only strategy the federal government, with regard to physician fees now has, is the "temporary freeze." Mr. Toby responded at length to questions and comments from the audience.

On November 2, 1983, J. Richard Goldstein, M.D., Commissioner of Health of New Jersey, was the guest at the "First Wednesday" program. This program is open to all members of the Academy of Medicine and their spouses. Gerald Shapiro, M.D., is Chairman of "First Wednesday at the Academy."

The Academy of Medicine now has formulated a Committee on Public Education, to be chaired by George Triebenbacher, M.D. The purpose of this Committee is to help fulfill the obligation of the medical profession, to provide information and education for the public. It is anticipated that the Academy will develop and maintain a file of members willing to speak before the public. Availability of these speakers and their topics then will be made known to legitimate community groups. An attempt will be made to match speakers as closely as possible with their local communities.

The Education Committee, chaired by Dr. Alfred Alessi, recently reviewed for CME Category I credit a "Clinicolegal Correspondence Course" prepared by James E. George, M.D., J.D., and others. The Academy was most impressed with the high quality of this course, and awarded 20 hours of CME Category I credit for successful completion. It is our understanding that this course will be made available to insured members of the Medical Inter-Insurance Exchange of New Jersey.

The Academy also is planning a "Symposium of Controversies in Geriatrics" to be held at the Headquarters Building on Wednesday, January 18, 1984. Frederick B. Cohen, M.D., is program chairman and moderator for this meeting.

The Internal Medicine Review Course 1984, sponsored by the Academy of Medicine, will be held under the chairmanship of Dr. Michael Bernstein. The course will begin on Wednesday, January 11, 1984, and run for 19 successive Wednesdays, at Overlook Hospital.

The Awards Committee, chaired by Dr. Rosemary Gellene is accepting nominations for the Edward J. Ill Award, and for the Citizen's Award. These awards are granted annually by the Academy of Medicine of New Jersey.

The first issue of the new monthly Program booklet has been sent to all members. The format, recommended by Dr. Robert Rigolosi, is expected to be especially convenient.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

CARDIOLOGY—Rakesh Kumar Gupta, M.D., P.O. Box 1452, Paintsville, KY 41240. All-India Institute of Medical Sciences 1975. Also, internal medicine. Solo hospital-based, group. Available.

Aubrey Orrin Lewis, M.D., 200 Carman Ave., Apt. 21-F, East Meadow, NY 11554. SUNY-Syracuse 1979. Also, general internal medicine. Board certified (IM). Solo, partnership, group, academic (cardiology). Available July 1984.

FAMILY MEDICINE—David Neidorf, M.D., 1701 Taxville Rd., Apt. 7A, York, PA 17404, SUNY-Stony Brook 1981. Board certified. Group, partnership, HMO. Available August 1984.

Jaime F. Lara, M.D., 6045 Palisade Ave., West New York, NJ 07093. Seville (Spain) 1979. Board eligible. Partnership or institutionally based. Available.

GASTROENTEROLOGY—Richard C. Dai, M.D., 16 Kenmar Dr., Apt. 127, Billerica, MA 01821. Chicago Medical School 1978. Also, internal medicine. Board certified (IM). Group or partnership. Available July 1984.

Joel Chodos, M.D., 3450 Wayne Ave., Bronx, NY 10467. Columbia 1975. Board certified. Also, general internal medicine. Group, partnership, hospital. Available July 1984.

Albert M. Harary, M.D., 2121 N. Bayshore Dr., Apt. 1001, Miami, FL 33137. Columbia 1978. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1984.

INTERNAL MEDICINE—J. Walter Sledge, M.D., 2115 Bedford Way, Columbia, SC 29209. University of Alabama School of Medicine 1978. Board certified. Group, partnership, solo. Available June 1984.

Richard C. Dai, M.D., 16 Kenmar Dr., Apt. 127, Billerica, MA 01821. Chicago Medical School 1978. Also, gastroenterology. Board certified. Group or partnership. Available July 1984.

Rakesh Kumar Gupta, M.D., P.O. Box 1452, Paintsville, KY 41240. All-India Institute of Medical Sciences 1975. Also, cardiology. Solo, hospital-based, group. Available.

Patricia M. Romano, M.D., 1077 Rive Rd., N608, Edgewater, NJ 07020. Corne University Medical College 1979. Als pulmonary. Board certified. Group. Avai able July 1984.

Laurence M. Silverstein, M.D., 500 Av G, #7, Redondo Beach, CA 90277. Albe Einstein 1979. Board certified. Availabl

Yi-po Wu, M.D., 32 Hapgood Wa Shrewsbury, MA 01545. National Taiwa University Medical College 1972. Boar eligible. Group or partnership.

Arvind Mehta, M.D., 8051 N. Hanover St Anaheim, CA 92861. Seth G.S. Medic College (India) 1975. Also, nephrolog Board eligible. Solo, group, associat Available.

Elliott Friedman, M.D., 25 Penny La., Ba timore, MD 21209. SUNY-Syracuse 197 Subspecialty, endocrinology. Boar certified—1M; board eligible—endo crinology. Group or partnership (bot specialties). Available July 1984.

Lee W. Hoffer, M.D., 1017 East 80th St. Brooklyn, NY 11236. Rome (Italy) 1980 Solo, partnership, group. Available.

Harold J. Brown, M.D., 260 Eggerts Rd. Lawrenceville, NJ 08648. UMDNJ 1982 Primary care clinic, HMO, group, partner ship. Available July 1985.

NEPHROLOGY—Arvind Mehta, M.D. 8051 N. Hanover St., Anaheim, CA 92861 Seth G.S. Medical College (India) 1975 Also, internal medicine. Board eligible Solo, group, partnership. Available.

NEUROLOGY—Elizabeth Kamenar, M.D. 12701 Shaker Blvd., Apt. 410, Cleveland OH 44120. Ohio State 1975. Board eligible Group, partnership, academia. Available July 1984.

Robert P. Rubens, M.D., 105 Ward St. Apt. 204, Seattle, WA 98109. UMDNJ New Jersey Medical School 1980. Boarc eligible. Available July 1984.

OBSTETRICS/GYNECOLOGY—Angela McVey, M.D., 3191 Agate St., Philadelphia, PA 19134. Bucharest Medical School (Rumania) 1949. Board eligible. Group, partnership, hospital, academia. Available.

Joseph Booker, Jr., M.D., 2500 Milvia St., Apt. 228, Berkeley, CA 94704. University of California-San Francisco 1973. Partnership, group, solo. Available.

Wook Chung, M.D., 2212 Watterworth Dr., Kalamazoo, MI 49008. Catholic Medical College (Korea) 1967. Board certified. Solo, group, partnership. Available.

Alan M. Askinas, M.D., 1309 Carrollton, Apt. 321, Metairie, LA 70005. Illinois 1980. Board eligible. Group, partnership, solo, part academic. Available July 1984.

Iris E. Dominy, M.D., 108 Pinegate Circle, Apt. 2, Chapel Hill, NC 27514. Albany 1978. Board eligible. Partnership or group in metropolitan area. Available July 1984.

OPHTHALMOLOGY—Steven R. Davis, M.D., 1000 Lakeview Rd., Clearwater, FL 33516. University of Alabama 1975. Board certified. Solo or association. Available.

Andrew Gewirtz, M.D., 519 Beach 133 St.,

Belle Harbor, NY 11694. Chicago 1978. Board eligible. Board certified (pediatrics). Group or partnership. Available July 1984.

ATHOLOGY—Mark A. Grathwhol, M.D., 2510 West Tremont Ct., Richmond, VA 23225. NYU 1980. Group. Available July 1984.

EDIATRICS—Howard Mintz, M.D., 60 Presidential Plaza, Apt. 308, Syracuse, NY 13202. Pittsburgh 1981. Board eligible. Group or partnership. Available July 1984.

ULMONARY DISEASES—Patricia M. Romano, M.D., 1077 River Rd., N608, Edgewater, NJ 07020. Cornell University Medical College 1979. Also, internal medicine. Board certified (IM). Group. Available July 1984.

James Kohan, M.D., 19 Highmanor Dr., Henrietta, NY 14467. Virginia 1979. Also, general internal medicine. Board certified (IM). Group, partnership, solo, institutional. Available July 1984.

ADIOLOGY/NUCLEAR MEDICINE—Conrad P. Ehrlich, M.D., 1243 Beacon St., Apt. 3-B, Brookline, MA 02146. Boston 1976. Board certified (also IM). Group or partnership. Available July 1984.

HEUMATOLOGY—Richard Furie, M.D., 435 E. 70th St., Apt. 8-F, New York, NY 10021. Cornell 1979. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1984.

URGERY, GENERAL—Ramon J. Gomez, M.D., 40-71 Gleane St., Elmhurst, NY 11373. University of the East (Philippines) 1978. Group or hospital-based emergency medicine practice. Available.

Ravinder Jagpal, M.D., 3408 Balboa La., Apt. 33, Columbia, MO 65201. Rutgers 1981. Also cardiothoracic surgery. Board certified (general surgery); board eligible (cardiothoracic surgery) Group. Available July 1984.

URGERY, ORTHOPEDIC—Jeffrey H. Charen, M.D., 155 Lexington St., Apt. 15, Auburndale, MA 02166. Rochester 1978. Board eligible. Group, partnership, solo (central or northern NJ preferred). Available January 1984.

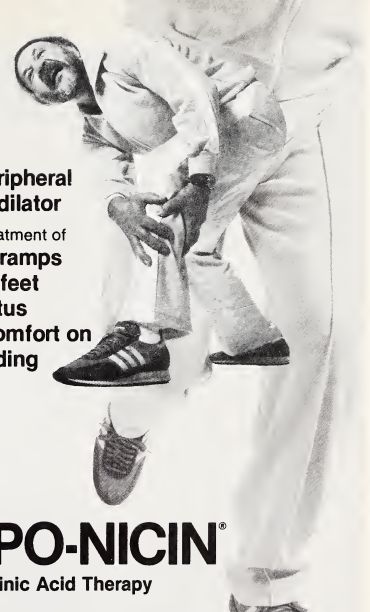
Oscar A. Reicher, M.D., 71 Brookwood Ter., Nashville, TN 37205. Pittsburgh 1979. Solo or group. Available July 1984.

Richard Lebovicz, M.D., 415 Grand St., New York, NY 10002. SUNY-Downstate 1979. Group or partnership. Available July 1984.

Salvatore Inserra, M.D., 1847-79th St., Brooklyn, NY 11214. NYU 1979. Board eligible. Group, partnership, solo. Available July 1984.

UROLOGY—Barlow S. Lynch, M.D., 5145 Linda Lou Dr., Carmichael, CA 95608. SUNY-Buffalo 1977. Board eligible. Partnership, group, solo, academic. Available July 1984.

Joseph G. Colonna, M.D., 1234 Van Voorhis Rd., Apt. C-6, Morgantown, WV 26505. Guadalajara (Mexico) 1977. Board eligible. Group or partnership. Available October 1984.



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MEDICAL PHILATELY

Milestones in Modern Medicine

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DESCRIPTIVE ANATOMY

Marie Francois Xavier Bichat (1771-1802) was born in Thoirette, France. He studied medicine at Lyons, and in 1793 went to Paris to become student, assistant, and finally successor to the famous French surgeon, P.J. Desault, at the Hôtel Dieu, a charity hospital in Paris.

During the French Revolution, the guillotine provided Bichat with 600 human bodies which he dissected meticulously. This gave him the background for his "Traite des Membranes" and his five-volume work, "Anatomie Descriptive." In these works Bichat gave detailed descriptions of the tissues in healthy and diseased bodies. These works had a profound influence upon pathology, particularly upon clinical medicine. He is considered "the father of descriptive anatomy."

Bichat died of tuberculosis meningitis at the age of 31. Corvisart stated, "No one has done so much and so well in so short a time." By order of Napoleon, a bust of Bichat was placed at the Hôtel Dieu.



Bichat
France, 1959

PHYSIOLOGY

Claude Bernard (1813-1878), the great French physiologist, received his medical degree in 1843 but never practiced medicine. All of his discoveries were based upon isolated facts. He had the rare ability to relate facts into larger physiological correlations which he proved by experimentation on living animals. Bernard was the first to recognize the metabolic function of the circulation of the blood in all life processes.

Bernard's three outstanding contributions to physiology were the demonstrations of the role played by the pancreatic juice in digestion; the discovery of the glycogenic function of the liver and the demonstration of the vasomotor mechanism.

Bernard received all the honor France could bestow. In 1898, he was created a senator by imperial decree of the Second Empire. Upon his death France honored him with a public national funeral.



Bernard
France, 1978

LETTERS TO THE EDITOR

Williams Issue

September 12, 1983

Dear Doctor Krosnick:

Thank you for the copy of the William Carlos Williams Commemorative Issue. When I came home from school yesterday, I sat down to sit in traction for arthritis of the neck, with the mail beside me. Your envelope was the last I opened, but I spent the most time with it. Sitting in traction is boring, and I usually read; this time I read with considerable gusto.

Whenever I teach about Williams I invariably emphasize his New Jersey background and stress his medical studies. In the back of my mind I hope that some day one of my students will become a writer albeit a doctor, lawyer, engineer, waitress, or factory worker. I doubt any of them will achieve his eminence, but I do give them lots of encouragement.

I finished reading the journal cover to cover after dinner and enjoyed every minute of it. On Monday I will share it with the other members of my English department at Mother Seton Regional High School, Clark.

One of the articles mentioned Williams was an enigma to his peers in the medical profession. Apparently the medical profession now has more humanists who recognize his unique talents. I must say that my first week of school was illuminated with pleasure by your gift. Somewhere or other I hope his spirit knows the honor you bestowed upon him and the pleasures I have experienced so often when teaching "The Use of Force" and "This Is Just To Say."

(signed) Mary E. Schmidt

Ed. note: A copy of the Williams Commemorative Issue was sent free of charge to all high school English teachers, public libraries, and medical libraries in the state.

September 19, 1983

Dear Doctor Krosnick:

Please convey my pleasure and appreciation to those who thought about including English teachers in the distribution of the William Carlos Williams Commemorative Issue.

I already have enjoyed it very much and will continue to do so, as well as use it with profit. Your group showed a fine sensitivity and generosity to the teaching profession in this most appropriate gesture.

(signed) Mrs. Eleanor DeYoung

Alert Era

September 4, 1983

Dear Doctor Krosnick:

I commend you for publishing "Consequences of Living in a Hair-Trigger Alert Era" by Donald B. Louria, M.D. Some may criticize the selection of such an article for a professional journal. However, there are some problems of such overwhelming importance that they deserve everyone's attention, however it can be obtained. The survival of the human race certainly is one of these issues.

Sadly, we already are seeing the changes Dr. Louria enumerates in some of our young people. If there is anything optimistic about our present dilemma, it is that there are those who keep reminding us about it when we would rather forget.

(signed) Owen A. Shteir, M.D.

Dispensing of Controlled Substances

September 6, 1983

Dear Doctor Krosnick:

I note that renewal applications for registration of dispensers of controlled substances now are on a quarterly rather than annual basis, and that registration fees have doubled.

Many mailings by the federal government contain an enclosure pertaining to the "Paperwork Reduction Act of 1980." There must be valid, reasonable, and justifiable reasons for this increase in paperwork and accompanying increase in fees, and I think these actions are of sufficient interest to all New Jersey physicians for MSNJ to obtain and publish the reasoning behind these added requirements.

(signed) Samuel Berg, M.D.

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January
1/4-6/20 Internal Medicine Board Review, Wednesdays, 4-7 PM

March
12-16 Managing Clinical Problems in the Elderly (Cerromar Beach Hotel/Puerto Rico)
19-23 Seminar in Advanced Rheumatology
26-30 Anesthesiology: Comprehensive Review III

April
27 Electomyography in the Courtroom
26-28 Update in Clinical Dermatology

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CARDIOLOGY UPDATE. . .

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WEDNESDAY, JANUARY 4, 1984

SICK SINUS SYNDROME

MODERATOR: LEONARD N. HOROWITZ, M.D.

3:00 CASE PRESENTATION	*Leonard N. Horowitz, M.D.*
3:00 THE DEFINITION AND RECOGNITION OF SICK SINUS SYNDROME	*Allan M. Greenspan, M.D.*
3:30 PACEMAKERS: 1984	*Scott R. Spielman, M.D.*
4:30 PRESYNCOPE AND SYNCOPE IN THE PATIENT WITH A PERMANENT PACEMAKER	*Leonard N. Horowitz, M.D.*
5:00 PANEL DISCUSSION	

LECTURE HALL "A"—2nd floor New College Building, Hahnemann University
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CME CALENDAR

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Jan.

7 **Postoperative Effects of Anesthetic Agents**
7:45-8:45 p.m.—Ramada Inn, Clark
(NJ State Society of Anesthesiologists and AMNJ)

Feb.

11 **Clinical Anesthesia 1984**
8 a.m.-3:50 p.m.—UMDNJ-New Jersey Medical School, Newark
(UMDNJ)

CARDIOLOGY

Feb.

16 **Pathophysiology and Management of Angina Pectoris**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center)

MEDICINE

Jan.

4 **Nonoperative Management of Chronic Back Pain**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

4 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

4 **Application of Beta-Blocking Drugs and Calcium Inhibitors to Treatment of Angina, Hypertension, and Arrhythmia**

11 **Evaluation and Management of Chronic Liver Disease**

25 **Arthritis-Differential Diagnosis and Modern Treatment**
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

4 **Endocrine Conferences**

11 3:30-5 p.m.—Rotates between Newark

18 Beth Israel Medical Center, University

25 Hospital, and United Hospitals Medical Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

5 **Children with Leukemia**
9 a.m.—Freehold Area Hospital
(AMNJ)

5 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section, AMNJ)

6 **Medical Grand Rounds**
11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section, AMNJ)

6 **Renal Conferences in Nephrology**

20 4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMNJ)

10 **Newer Cardiac Drugs**

24 **Emergency Care-Cardiac/Drug Overdose**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

11 **Glycosylated Hemoglobin and Home Glucose Monitoring**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

11 **Insulin Infusion Pump Therapy in the Ambulatory Setting**

25 **Bronchogenic CA and Mesothelioma Associated with Asbestosis**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital)

12 **Allergy, Current Status**
2 p.m.—John E. Runnells Hospital of Union County
(AMNJ)

16 **Hemoglobinopathies**
12 noon-1 p.m.—The Mountainside Hospital, Montclair
(The Mountainside Hospital)

17 **Salt Retention and Medullary Hemodynamics**
4-5 p.m.—Academic Health Service Center, New Brunswick
(UMDNJ)

18 **Congestive Heart Failure**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

18 **Controversies in Medicine-Geriatrics**
1 p.m.—Medical Society of New Jersey, Lawrenceville
(AMNJ)

18 **Dermatological Conference**
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

19 **Newer Antibiotics-Rationale for Selection**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

19 **New Approaches to the Nutritional Treatment of Hypertension**

26 **Beta-Blockers in Postmyocardial Infarction Patients**
11 a.m.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital)

20 **Regional Hospital Case Presentations**
8-10 p.m.—St. Barnabas Medical Center, Livingston
(NJ Gastroenterological Society and AMNJ)

20 **Intraventricular Hemorrhage in the Newborn**
8-9:30 a.m.—Overlook Hospital, Summit
(Overlook Hospital)

25 **Clinical Manifestation of Autoimmune Disease**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

Feb.

1 **Endocrinology Series-Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange

2 9:30 a.m.—Newark Beth Israel Medical Center, Newark

3 11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section, AMNJ)

1 **Endocrine Conference**

8 3:30-5 p.m.—Rotates between Newark

15 Beth Israel Medical Center, University

22 Hospital, United Hospitals Medical

29 Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

1 **Newer Insulins**

8 **Congenital Pulmonary Anomalies**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital)

2 **The Current Status of Antiviral Chemotherapy**
11 a.m.-12:30 p.m.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)

3 **Renal Conference in Nephrology**

17 4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ, Nephrology Section, and AMNJ)

7 **Geratrics-Medication Prescribing Practices**

21 **Hypertension-Malignant**
11-12 noon—Greystone Park Psychiatric Hospital, Greystone Park
(Greystone Park Psychiatric Hospital)

15 **Rutgers Dermatological Conference**
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

17 **Management of Portal Hypertension**
8-9:30 a.m.—Overlook Hospital, Summit
(Overlook Hospital)

21 **Nephrotoxicity-1984: An Update**
4-5 p.m.—Academic Health Service Center, New Brunswick
(UMDNJ)

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1:00 p.m.—5:00 p.m.
at
MSNJ HEADQUARTERS BUILDING
Lawrenceville, New Jersey

The symposium will identify specific medical and social problems of the aged. In addition we plan to determine who should be in charge of the elderly: a primary care physician, or a specialist in geriatrics. Finally we plan to decide whether or not geriatrics is a specialty of medicine. The program is designed for internists, family practitioners, administrators of long term care facilities and other interested professionals.

For further information contact:
EXECUTIVE OFFICES
The Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
(201) 896-1717

The Academy of Medicine of New Jersey
in cooperation with
Overlook Hospital
presents

"AN INTENSIVE REVIEW OF INTERNAL MEDICINE"

JANUARY 11, 1984 to MAY 16, 1984
(19 Successive Wednesdays)
3:00 P.M.-6:00 P.M.
at
OVERLOOK HOSPITAL
SUMMIT, NEW JERSEY

The course is designed to assist participants in their preparation for the Internal Medicine certification (and recertification) exam scheduled for the Fall of 1984. It is also provided as a review of recent advances for private practicing internists, family practitioners and residents. Syllabus material will be distributed during the course and section chairmen have been encouraged to invite out-of-state guest lecturers to participate in each of eleven disciplines.

Course Chairman:
Michael Bernstein, M.D.

For further information on registration, faculty, and fees, please contact:
Ms. Henrietta Golub
The Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
Phone: (609) 896-1717

Sodium Homeostasis in Liver Disease
7-8 p.m.—Ramada Inn, Clark
(Nephrology Society of New Jersey)

2 Pulmonary Function Tests and Emphysema
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

2 Renal Hypertension or HPN Secondary to Kidney Disease
1:00 to 2:30 p.m.—VA Medical Center, Lyons
(Veterans Administration Medical Center)

9 Evaluation and Treatment of Occupational and Environmental Lung Disease
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital)

9 Ophthalmology Associated with Systemic Diseases
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

NEUROLOGY/PSYCHIATRY

Jan.

9 Can't Go Home at 36
8:15-10:30 p.m.—111 Ridgewood Ave., Glen Ridge
(Essex Psychiatric Seminar and AMNJ)

10 Psychopharmacology
3 p.m.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

12 Psychoanalytic Aspects of Non-compliance in Cancer Patients
8-10 p.m.—Hackensack Medical Center, Hackensack
(New Jersey Psychoanalytic Society)

16 Principles of Child Psychotherapy
8:30-10:30 p.m.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

18 Mind Bending By Drugs, Intentional and Accidental
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

26 Hypnosis in Medical Practice
12 noon—J.F. Kennedy Medical Center, Edison
(AMNJ)

PEDIATRICS

Jan.

5 Children with Leukemia
9 a.m.—Freehold Area Hospital
(AMNJ)

20 Intraventricular Hemorrhage in the Newborn
8-9:30 a.m.—Overlook Hospital, Summit
(Overlook Hospital)

RADIOLOGY

Jan.

16 Ultrasound
12:30 p.m.—Columbus Hospital
(AMNJ)

18 Dinner Meeting
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

20 Radiology Meeting
7:30-10 p.m.—St. Barnabas Medical Center, Livingston
(Radiological Society of NJ and Radiology Section, AMNJ)

Feb.

16 Radiology Meeting
7:30-10 p.m.—St. Barnabas Medical Center, Livingston
(Radiological Society of NJ, Radiology Section, and AMNJ)

SURGERY

Jan.

4 Surgical Departmental Conferences
11 8:30-10 a.m.—Rutgers Medical School,
18 New Brunswick
25 *(UMDNJ)*

Feb.

1 Surgical Departmental Conferences
8 8:30-10 a.m.—Medical Education Bldg.,
15 Rutgers Medical School,
22 New Brunswick
29 *(UMDNJ)*

15 Thyroid, Parathyroid Surgery
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

SURGICAL SPECIALTIES

Jan.

3 Lung Cancer
7:30 p.m.—Burdette Tomlin Memorial Hospital, Cape May Court House
(AMNJ)

5 Vascular Surgical Rounds
12 4-5 p.m.—Rutgers Medical School,
19 New Brunswick
26 *(UMDNJ)*

18 GI Surgery for Ulcer
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

24 Intracranial Bypass Surgery
7:30-8:30 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

Feb.

2 Vascular Surgical Rounds
9 4-5 p.m.—Rutgers Medical School,
16 New Brunswick
23 *(UMDNJ)*

15 When and Why To Replace Which Joint-An Update
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital)

Feb.

3 Psychiatric Aspects Concerning the Prevention of Nuclear War
8:30-10:30 p.m.—The Atrium West, West Orange
(New Jersey Psychiatric Association)

6 Anorexia in a Professional Woman
8:15-10:30 p.m.—Office of Rita Newman, M.D., 543 Park St., Upper Montclair
(Essex Psychiatric Seminar)

8 Muscle Weakness-Approach to Diagnosis and Treatment

22 Fits and Faints
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital)

15 Sleep Onset Insomnia: Assessment and Clinical Management
1-2:30 p.m.—Christ Hospital Jersey City
(Christ Hospital)

15 Treatment of the Agitated Elderly Patient
1:00 to 2:30 p.m.—VA Medical Center, Lyons
(Veterans Administration Medical Center)

20 Principles of Child Psychotherapy
8:30-10:30 p.m.—Office of Lawrence Deutsch, M.D., Englewood
(New Jersey Psychoanalytic Society)

OBSTETRICS/GYNECOLOGY

Feb.

1 Amenorrhea
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital)

1 Diagnosis and Treatment of Incontinence in Geriatric Patients
1:30 p.m.—Essex County Hospital Center, Cedar Grove
(Essex County Hospital Center)

1 Laparoscopy, Colposcopy, Infertility
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

2 Fetal Visualization of Prenatal Diagnosis
9:00 a.m.—Freehold Area Hospital, Freehold
(Freehold Area Hospital)

21 Prevention and Treatment of Decubitus Ulcers
12 noon—St. Mary's Hospital, Orange
(St. Mary's Hospital)

PATHOLOGY

Jan.

5 Chemical Carcinogenesis of Chronic
12 Tumor Promotion
19 Chemical Carcinogenesis Evaluation Systems—In Vitro/In View
26 Radiation Carcinogenesis
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

11 Pathology Grand Rounds
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

Feb.

2 Macrophages and Their Relations to Neoplasia
9 Natural Killer Cells
16 Cell-Mediated Immunity and Regulatory Cells
23 Tumor Protective and Facilitating Antigens
4-6 p.m.—Institute for Medical Research, Camden
(Institute for Medical Research)

8 Pathology Grand Rounds
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

OBITUARIES

Dr. Theodore L. Dulany

Theodore L. Dulany, M.D., died on September 19, 1983. A member of our Essex County component, Dr. Dulany also was a member of the American Medical Association.

Dr. Stephen A. Foldy

Word has been received of the death of Stephen Andrew Foldy, M.D., on July 4, 1983. Born in 1941, Dr. Foldy earned his medical degree at the University of Medicine and Dentistry in 1969. A family practitioner, Dr. Foldy was a member of our Union County component and a Diplomate of the American Board of Family Practice.

Dr. A. Joseph Hughes

At the age of 69, A. Joseph Hughes, M.D., died on October 1, 1983. Dr. Hughes was a graduate of Hahnemann Medical College, Pennsylvania, in 1939. During his career, Dr. Hughes was affiliated with Our Lady of Lourdes Hospital, Camden, and the New Jersey Department of Health where he served as deputy commissioner of health, chief of the division of tuberculosis, and director of the division of preventable diseases. An emeritus member of our Camden County component, Dr. Hughes was a member of the American Medical Association and a Fellow of the American College of Physicians.

Dr. George W. Irmisch

George William Irmisch, M.D., formerly a member of our Mercer County component, died on September 27, 1983. Born in 1913, Dr. Irmisch earned his medical degree at Temple Medical School, Philadelphia, in 1940. Dr. Irmisch maintained a urologic practice in Trenton from 1948 until 1975 when he moved to New York. During his lengthy career, Dr. Irmisch was chief urologist and president of the medical staff at Helene Fuld Medical Center and Hamilton Hospital, both in Trenton. In addition, he was affiliated with two other Trenton hospitals: St. Francis Medical Center and Mercer Medical Center. Dr. Irmisch was a Diplomate of the American Board of Urology, a member of the American Medical Association and of the New York Medical Society, and a Fellow of the American College of Surgeons and of the International College of Surgeons.

Dr. George E. Michell

George Edmund Michell, M.D., a retired member of our Warren County component, died on July 18, 1983. Born in 1899, Dr. Michell earned his medical degree at Toronto Medical School in 1924. A family practitioner, Dr. Michell was affiliated with Memorial Hospital, Morristown, and Braddock General Hospital, Pennsylvania. Dr. Michell was a member of the American Medical Association.

Dr. J. Lloyd Morrow

At the age of 70, J. Lloyd Morrow, M.D., died on September 21, 1983. Dr. Morrow received his medical degree from McGill University Medical School, Canada, in 1939. A psychiatrist, Dr. Morrow was affiliated with Chilton Memorial Hospital, Pompton Plains, General Hospital, Wayne, and General Hospital, Passaic. A member of our Passaic County component and of the American Medical Association, Dr. Morrow was a Diplomate of the American Board of Psychiatry and Neurology and a Fellow of the American College of Physicians.

Dr. Charles G. Prather

A retired member of our Bergen County component, Charles Givens Prather, M.D., died on September 9, 1983. Born in 1904, Dr. Prather received his medical degree from the University of Arkansas School of Medicine in 1929. Dr. Pather was attending surgeon of Holy Name Hospital, Teaneck, and after retiring from practice in 1959, he became director of professional services in hospitals for the U.S. Veterans Administration in South Carolina, Tennessee, and Kansas. In 1980, Dr. Prather was honored with MSNJ's Golden Merit Award for 50 years of distinguished service as a physician. Dr. Prather was a Fellow of the American College of Surgeons and the American Society of Abdominal Surgeons.

Dr. Seymour Saxanoff

Seymour Saxanoff, M.D., a member of our Middlesex County component, died on October 3, 1983. Dr. Saxanoff received his medical degree from Thomas Jefferson University, Pennsylvania, in 1963. He interned at Cedars of Lebanon Hospital, California, and completed his training in radiology at Temple University Medical Center, Philadelphia. In 1970, Dr. Saxanoff joined the Radiology Group of New Brunswick, PA. An expert in orthopedic radiology and arthrography, Dr. Saxanoff was a Diplomate of the American Board of Radiology, and a member of the American Medical Association, of the American College of Radiology, and of the New Jersey Radiological Society.

Dr. Francis C. Weber

At the grand age of 90, Francis Charles Weber, M.D., died on September 20, 1983. Dr. Weber received his medical degree from Jefferson Medical College, Pennsylvania, in 1917. He was a cardiologist in Newark for 56 years before retiring in 1973. In addition, he was the plant physician for E.I. Dupont Corporation, Newark, for over 40 years. During his lengthy career, Dr. Weber was affiliated with Martland Medical Center, St. Michael's Medical Center, and Presbyterian Hospital, all in Newark. A retired member of our Essex County component, Dr. Weber was a member of the American Medical Association, and a Fellow of the American College of Cardiology. In 1967, Dr. Weber received MSNJ's Golden Merit Award for 50 years of service as a physician.

Dr. Robert L. Yager

Robert Louis Yager, M.D., a member of our Hudson County component, died by accidental drowning on October 1, 1983. Born in 1931, Dr. Yager received his medical degree from New York University School of Medicine in 1956. An internist, Dr. Yager was affiliated with Christ Hospital, Jersey City, North Hudson Hospital, Weehawken, and Martland Hospital, Newark. Dr. Yager was a Diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians.

Cardiac Surgery and the Conduction System

Saroja Bharati, M.D., Maurice Lev, M.D., John W. Kirklin, M.D. New York, NY, John Wiley & Sons, 1983. Pp. 107. Illustrated. ($55)

This well-illustrated, compact atlas covers that portion of cardiac surgery for congenital defects with special attention to the conduction system. The location of this system in normal and abnormal hearts is well understood but the risk with certain types of cardiac surgery is great. Such aberrations as atrial and ventricular septal defects, intra-atrial transposition of venous return, and septal defects of a single ventricle present special problems with surgery.

This book acknowledges the problem, presents a brief review of anatomy, orients the reader with excellent illustrations and descriptions, and describes in intricate detail the exposure so the plan and execution of surgery is faultless.

The subject is highly specialized, directed at cardiac surgical residents or fellows, as well as cardiac surgeons. The saying "One picture is worth one thousand words," is true for this text has about 50 to 60 pictures. *Cardiac Surgery and the Conduction System* would make a worthy addition to the library of any practitioner so specialized.

Manuel J. Rowen, M.D.

Clinical Gastroenterology, Third Edition

Howard M. Spiro, M.D. New York, NY, Macmillan Publishing Co., Inc., 1983. Pp. 1549. ($88)

Often we read of the characteristics of the ideal medication for a certain disease—highly effective, rapid acting, and free of unpleasant effects. Alas, such a medication never is available. For the reading medical public affected by boredom, here is the near-perfect cure. Now in its third edition, this massive volume is the work of Dr. Spiro.

The book is well organized into 11 units, i.e. esophagus, stomach, ulcer, liver, and subdivided further into 60 chapters; the text has a very good index, enabling the reader to find certain specific information easily. The material gratifyingly is detailed, yet succinct and intelligently illustrated.

The outstanding feature is Dr. Spiro's personal witty style. He is very practical and often adds his personal philosophy and incisive humor. Dr. Spiro ventures to puncture some balloons, such as gastroenterologists not endoscoping at every opportunity. He deals with several of our clinical frustrations, for example our failure to improve on our methods and success rate in the treatment of alcoholic liver diseases over the past 35 years of his own experience. His wisdom and honesty are refreshing and very unusual in such prestigious textbooks. He is instructive in stressing the limits for tests, the false positives and negatives, and the need for good clinical judgment at all times.

I strongly recommend this book for purchase and especially for reading.

Norman Riegel, M.D.

Endocrinology

Harold E. Carlson, M.D., (ed). New York, NY, John Wiley & Sons, Inc. 1983. Pp. 308. ($35)

The preface to this book can be quoted almost verbatim; it spells out concisely and neatly the theme and purpose: "This book has been designed to provide internists and other practitioners with a review and update of modern clinical endocrinology. It is not all inclusive, but focuses on the disorders most commonly seen in medical practice. The first chapter provides an overview of recent major advances in the understanding of how hormones act and relate these observations to the human endocrine dysfunctions. Clinical chapters follow and are concerned with the various endocrine glands. The final chapter discusses autoimmune diseases as they effect the endocrine system."

As stated, the book is typical of a summary of lectures given by individual authors and is not a thorough encyclopedic volume. It would be more appropriate for students or clinicians who need a fast review course. Case discussions are given to illustrate specific endocrine gland pathology at the end of each chapter, with a description of the problem followed by questions, answers, and comments.

Chapters end with lists of suggested reading references.

Harry M. Poppick, M.D.

The Neurology of Aging

Robert Katzman, M.D., and Robert Terry, M.D. Philadelphia, PA, F. A. Davis Co., 1982. Pp. 249. Illustrated. ($38)

After rapidly reading through this small volume I went back and reread selected areas at different times. Each encounter produced a gem of useful information or a new way to look at the various ramifications of aging. Every chapter has points of view and items of interest for every specialty in medicine and every general list that deals with the ever-increasing older population.

The perspective perhaps is presented best in the paragraph: "We all tend to see older individuals as being younger or older than their chronologic age. Physicians often classify older patients in a similar manner, remarking that functional or physiologic age is more important medically than chronologic age. In fact, there is little evidence to support such an assertion. The significant factors in aging are our proximity to our genetically determined maximum life span and the presence or absence of disease processes involving more than one body system." Keeping this tenet in mind should aid in the care of our ever-increasing aged population.

The editors have been able to lend a continuity in the ten chapters by 15 contributors. They present the rapidly expanding body of clinical knowledge concerning both normal aging and neurologic diseases helping the reader to separate the pathology that requires treatment from the "normal" processes.

Buy this book. You will turn back to it repeatedly. The references are up to date. The illustrations are lucid and the tables are simple and useful.

Henry R. Liss, M.D.

Physicians' Guide to Diseases of the Oral Cavity

Harriet S. Goldman, D.D.S., and Michael Z. Marder, D.D.S. Oradell, NJ, Medical Economics Books, 1982. Pp.

230. Illustrated. ($39.50)

The authors of this book are to be commended for doing a splendid job covering a very difficult area. There is no one specialty that studies only the oral manifestations of systemic disease and I feel this text will be a great help to all practitioners when diagnosing diseases of the oral cavity.

The organization of this text also is very good. When a patient enters the physician's office with a problem, it is easy to locate the chapter that pertains to the lesion in question. Another great advantage of this book is its completeness; one would have a difficult time finding a disease not mentioned.

I assume that there was technical difficulty in publishing when all the color photographs were placed together. This is a slight disadvantage because when reading the book you see a black and white picture that may not be adequate and then you have to refer to the color photograph for verification.

I would recommend this book without reservation to be kept as a reference in any medical or dental office.

Harold Arlen, M.D.

Pleural Diseases

Richard W. Light, M.D. Philadelphia, PA, Lea & Febiger, 1983. Pp. 269. ($33)

Dr. Light's concise and well-organized volume on pleural diseases is a welcome addition to the pulmonary literature. It explains in a clear, well-organized fashion a subject which, in the past, only has been covered sketchily in standard pulmonary textbooks. The chapter headings and the table of contents clearly spell out what is to follow in the 24 chapters of material. The 17-page index is complete and details whether the reference is for text, figures, or tables. An extensive bibliography with multiple authors cited appears at the end of the each chapter.

The role of ultrasound and CT is well defined. There are very practical pointers regarding the efficacy of a diagnostic pleural tap which has not been emphasized in the past. Chapter 4 covering the analysis of pleural fluid contains many little-known pearls of particular value to the clinician. The complete table of differential diagnosis and an algorithm on various characteristics of pleural fluid and for proceeding diagnostically is excellent. Chapter 7 detailing the sclerosing agents with the reasons for success and failure is the most complete that I have seen in any pulmonary text. This is the most complete compendium of pleural diseases for the general internist as well as the pulmonologist recently published. A chapter on chest tubes, usually reserved for surgical textbooks, presents a good basic fund of knowledge for the medical chest physician.

This book is a valuable text for the personal library of the practicing physician.

Ellis P. Singer, M.D.

Practical Rheumatology

Timothy M. Spiegel, M.D., (ed). New York, NY, John Wiley & Sons, Inc., 1983. Pp. 383. ($29.95)

In his preface, Dr. Spiegel states that the goal of this book is to provide a "how to" approach to the diagnosis and management of rheumatic diseases for the primary physician. Initially an algorithm is presented which is indeed helpful; subsequent chapters concern the various diseases mentioned in this algorithm.

Following this portion, however, the book becomes disjointed and veers away from its purpose: the instruction of practical material for the primary physician. For example, in the chapter on laboratory tests in rheumatology, three pages are devoted to human leukocyte antigen while one small paragraph deals with synovial fluid analysis. If one is using the test as a reference guide it would be easy to miss another slightly longer discussion on synovial fluid analysis in the first chapter, "Approach to Diagnosis." There is no explanation given in "how to" aspirate a joint to obtain synovial fluid.

As often is the case with multiple authors, overlap of material and occasionally conflicting statements occur, i.e. in the chapter on rheumatological emergencies it is stated that management of alantoaxial subluxation may require attempt at reduction with cervical traction while in the chapter on rehabilitation measures it is stated that cervical traction generally should be avoided in patients with rheumatoid arthritis.

Long discussions on entities such as cricoarytenitis and Wegener's granulomatosis ensue even though these are extremely rare and probably never will be seen by most primary physicians. Other criticisms include the print being too small and not enough diagrams or tables.

Although there are some good individual chapters for the primary physician such as "Examination of the Musculoskeletal System" and "Musculoskeletal Syndromes of Work and Recreation," I cannot recommend this text as a reference book for practical rheumatology.

Sheldon N. Solomon, M.D.

Thin-Needle Aspiration Biopsy

William J. Frable, M.D. Philadelphia, PA, W.B. Saunders Company, 1983. Pp. 384. ($48)

This book represents volume 14 in the series, "Major Problems on Pathology." It is well bound, printed on excellent glossy paper, and profusely illustrated—all black and white with the exception of three pages of color plates. Since the paper is so good, the many black and white photomicrographs are satisfactory and a pleasure to examine.

Thin-Needle Aspiration Biopsy is comprised of 11 chapters and an excellent index. Chapter 1 is an introduction and history; Chapter 2 is important and discusses techniques of thin-needle aspiration biopsy; the following chapters discuss this diagnostic procedure as regards the breast, lymph nodes, salivary glands, thyroid, lung and mediastinum, gastrointestinal system, urogenital systems, and bone and soft tissue.

The final chapter is of special delight and is entitled, "Research and Special Applications." This chapter contains some very clear electronmicrographs on material obtained by fine-needle aspiration and emphasizes the techniques potential in research, such as scanning electronmicroscopy, DNA synthesis, and cell marker studies. A thorough reading of this book also offers a current review of nomenclature in surgical pathology as there are many photomicrographs of the surgical specimens removed after the fine-needle biopsy.

In my experience and travels, most surgical pathologists are highly interested in this diagnostic method, and most have taken at least one workshop on the subject. I agree with Dr. Frable that the hesitancy of acceptance of this procedure in this country (it has been used in Europe, particularly the Scandinavian countries) is in the training for surgical residents. Thus, I would recommend this as required reading for all residents in any of the surgical specialties and all residents in pathology. It is a good book and also should be of interest to medical oncologists and cytopathologists.

Hugh F. Luddecke, M.D.

INFORMATION FOR AUTHORS

The Journal, the official organ of the Medical Society of New Jersey, is published monthly under the direction of the Committee on Publication. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update, and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

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SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8-1/2" by 11" paper. This material is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 50-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8-1/2" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8-1/2" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis.* New York, NY, McGraw-Hill, 1969, Pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal,* MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

Housing Application

218th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY

MAY 3-6, 1984

	Single	Twin	Suites
Resorts International (headquarters hotel)	$80.00	$80.00	$171/$250
Harrah's Marina Hotel Casino	$75.00	$75.00	
World International Hotel/Motel	$58.00	$58.00	
Lafayette Motor Inn	$58.00	$58.00	

Rates subject to 12% state and local taxes; tax subject to change.

All hotel reservations for the 218th Annual Meeting of MSNJ will be handled by the Atlantic City Convention Bureau. Please send your housing application with your 1st, 2nd, and 3rd choices directly to the Bureau, 16 Central Pier, Atlantic City, NJ 08401. All Delegates and Members are urged to make their hotel reservations early. Blocks of rooms will be available at Resorts International (headquarters hotel), Lafayette Motor Inn, World International Hotel/Motel, and Harrah's Marina Hotel Casino. The cut-off date for reservations will be April 6, 1984. Reservations cannot be guaranteed after this date. No Saturday arrivals please. All registrants will be charged for three nights: Thursday, Friday, and Saturday, May 3, 4, and 5, 1984.

MAIL THIS APPLICATION DIRECTLY TO THE ATLANTIC CITY CONVENTION BUREAU
16 Central Pier
Atlantic City, NJ 08401

Please list 1st, 2nd, and 3rd choices; confirmation will come directly from hotel.

1st Choice _____ 2nd Choice _____

3rd Choice _____

Accommodations desired: ☐ Single ☐ Twin ☐ Suite Parlor & 1 Bedroom
☐ Suite Parlor & 2 Bedrooms

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Will arrive _____ (date) Time _____ Will depart _____ (date) Time _____

☐ Check if Official Delegate _____ County _____

1983 INDEX

Volume 80
January to December 1983

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cm—Commentary
ed—Editorial
hg—Hospital governing boards
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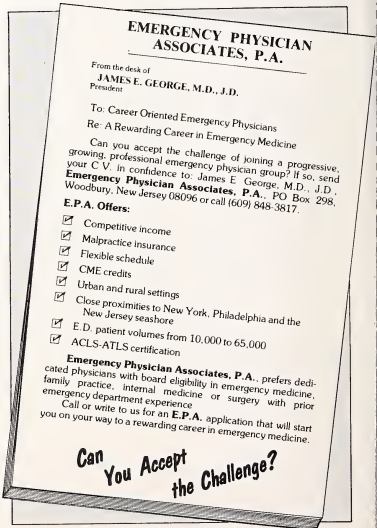
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